Conference on Medical Cost Containment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
1993

Conference on Medical Cost Containment March 2 – 4 1993

Report of Proceedings

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Lawrence W. Rogers, Director

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number

May 27, 1993

Dear Colleague:

Over the past ten to fifteen years we have witnessed a steep increase in the proportion of the nation's gross national product that is allocated to health care. Cost growth continues to accelerate, and exert an increasing influence on our activities. Charges under the Federal Employees' Compensation Program are no exception. Even though the Office of Workers' Compensation Programs has done several things that we believe have helped, or will help, to control the rate of medical cost increases under our programs, I believe we can do more.

That belief prompted us to host a conference on medical costs under FECA for representatives from Federal agencies, the U.S. Postal Service, and others with direct interests in our program. Our goal was to provide an opportunity to meet in an atmosphere that would encourage exploration of the issues, provide opportunity for discussion of options, and foster the desire to become involved in the solutions.

The conference was time well spent. A genuine spirit of collegiality stimulated the exchange of information. It was your willingness to discuss issues with the resolve to improve the FECA program, that made it possible to use our collective insight to develop some very concrete strategies.

As a result of this conference, we have already begun several initiatives, and are proceeding with others based on the strong support we received from the findings and suggestions made by the discussion groups. For example, we are:

1. Developing a cooperative structure with the Agency for Health Care Policy and Research (AHCPR) staff that will:

    - Assist us to adopt those portions of medical care standards promulgated by the AHCPR that are suitable for FECA (e.g. the standards for acute back pain expected later this year).

    - Provide for access to AHCPR research findings and resources to help us develop and resolve appropriate care, and expected length of recovery issues.

    - Provide for AHCPR to assist OWCP with a research design to measure and evaluate the effectiveness of medical cost containment and quality control procedures piloted or implemented by OWCP.

1916 1991
FEDERAL EMPLOYEES' COMPENSATION ACT
75
YEARS OF SERVICE TO THE FEDERAL WORKPLACE

2. Working with the Health Care Financing Administration (HCFA) to coordinate efforts for cost control through:

   - Use of a medical fee schedule for professional services that as a minimum: (1) uses the same relative value scale (RVS) for determining the work value, practice expense factor and malpractice factor for a medical procedure, and (2) uses the same data base for determining geographic variance in health care delivery costs.

   - The development of a method to utilize the Medicare DRG (diagnostic related group) reimbursement system for payment of inpatient services under FECA to broaden our cost control capabilities.

   - Use of HCFA-developed automated surveillance techniques for monitoring the quality and quantity of medical, and to curtail unbundling of comprehensive services.

3. Develop and test methods to (1) improve the early exchange of information between employing agencies and the DFEC District Office responsible for managing claims, and (2) introduce the use of intervention nurses into claims management soon after the injury.

I personally wish to thank each of you for taking the time to meet with us, and encourage you to continue working toward our mutual goals: to provide quality medical care for work-site related injuries and illnesses at a reasonable cost, and to return the injured employee to suitable work at the earliest appropriate time.

All of us thank the speakers for their excellent presentations. They helped clarify the issues and acted as an impetus for the discussions.

This summary of our conference proceedings is provided to you with my thanks. Please contact me if you have suggestions or wish additional information.

Sincerely yours,

Lawrence W Rogers

LAWRENCE W. ROGERS
Director, Office of Workers'
Compensation Programs

CONFERENCE ON THE MANAGEMENT OF MEDICAL COSTS
UNDER WORKERS' COMPENSATION

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U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number

OFFICE OF WORKERS' COMPENSATION PROGRAMS
AGENDA FOR CONFERENCE ON THE MANAGEMENT OF MEDICAL COSTS UNDER WORKERS' COMPENSATION

U.S. DEPARTMENT OF LABOR
2ND AND CONSTITUTION, N.W. WASHINGTON, D.C.
SEMINAR ROOM SIX
Department of Labor Academy
FIFTH FLOOR

TUESDAY MARCH 2 THROUGH THURSDAY NOON, MARCH 4, 1993

Tuesday, March 2, 1992

9:00 AM WELCOME — Lawrence W. Rogers, Director, Office of Workers' Compensation Programs

9:15 BRIEF OVERVIEW OF FECA LEGISLATION, REGULATIONS AND POLICY — Thomas Markey, Director, Division of Federal Employees' Compensation

9:30 OWCP's MEDICAL COST CONTAINMENT INITIATIVES - OVERVIEW — Lawrence W. Rogers

10:00 BREAK

10:15 MEDICAL COSTS UNDER FECA — Virginia Miller, M.D., Medical Director

Distribution of costs under the program - historic and current trends

Changes in the distribution of costs by nature of injury

Patterns of treatment and diagnostic procedures

11:45 LUNCH

1916 1991 FEDERAL EMPLOYEES COMPENSATION ACT 75 YEARS OF SERVICE TO THE FEDERAL WORKPLACE

Tuesday, March 2nd

PRESENTATIONS

1:00 PM Development of Treatment Guides

Barbara Flemming, M.D.
Senior Health Policy Analyst
Office of the Forum
Agency for Health Care Policy and Research

1:30 Industrial Injury Management from a Physician's Perspective

Edward Mills, M.D.
District Medical Director
Office of Workers' Compensation Programs
Seattle, Washington

2:00 Early Claim Management: Nurse Intervention As a Cost Containment Strategy

Charity Benz
Regional Director
Office of Workers' Compensation Programs
Boston, Mass.

2:30 The States' Efforts at Medical Cost Containment

Glenn Whittington
Chief, Branch of Planning,
Policy and Review, OWCP National Office

3:00 BREAK

3:15 Twenty-four Hour Coverage

Kevin Haugh, Ph.D.
Institute for Health Policy Solutions
Washington, D.C.

3:45 Medicare's DRG System

Charles Booth
Director, Office of Payment Policy
Health Care Financing Administration
Baltimore, Maryland

4:15 INSTRUCTIONS AND PANEL ASSIGNMENTS

Lawrence Rogers

4:30 ADJOURN

Wednesday - March 3, 1993

8:30 AM PANEL DISCUSSIONS - Development of Discussion Themes and Recommendations

Discussion Group participants will meet in assigned meeting rooms to discourse on the group's topic and for the development of recommendations/options.

DISCUSSION GROUP 1	Application of Standards of Medical Care to Services Under FECA
Chairperson:	Edward Mills, M.D. District Medical Director OWCP, Seattle, Washington
Meeting Place:	Seminar Room No. 2 on the Fifth Floor
DISCUSSION GROUP 2	Early Medical Management
Chairperson:	Charity Benz Regional Director OWCP, Boston, Mass.
Meeting Place:	Room S3215A
DISCUSSION GROUP 3	Automated Information Processing and Medical Cost Containment Initiatives
Chairperson:	Virginia Miller, M.D. Medical Director OWCP, National Office
Meeting Place:	Seminar Room S3215B
DISCUSSION GROUP 4	Twenty-Four Hour Coverage
Chairperson:	Glenn Whittington Chief, Branch of Planning, Policy and Review OWCP, National Office
Meeting Place:	Seminar Room Number Six

PRESENTATION OF PANEL CONCLUSIONS AND RECOMMENDATIONS

2:30 PM — Presentation by Discussion Group 1
Medical Standards

3:30 — Presentation by Discussion Group 3
Automated Information Processing and Medical Cost Containment

4:30 — ADJOURN

Thursday - March 4th, 1993

Presentation of Panel Conclusions and Recommendations - Continued

8:30 AM — Presentation by Discussion Group 2
Early Case Management

9:30 — Presentation by Discussion Group 4
Twenty-Four Hour Coverage

10:30 — BREAK

DISCUSSION OF PANEL CONCLUSIONS, RECOMMENDATIONS AND SUGGESTED INITIATIVES

10:45 — Prescriptions for the Future

Discussion Chairperson: Lawrence W. Rogers

CLOSING REMARKS

12:00 — Lawrence W. Rogers, Thomas Markey, Diane Svenonius

12:15 — Adjourn

CONFERENCE PRESENTATIONS ON MEDICAL COST ISSUES

1. VIRGINIA MILLER, M.D.

   Medical Costs Under the Federal Employees' Compensation Program

2. BARBARA FLEMMING, M.D.

   Development of Clinical Practice Guidelines

3. EDWARD H. MILLS, M.D.

   Industrial Injury Management from a Physician's Perspective

4. CHARITY I. BENZ

   Early Claim Management

5. GLENN WHITTINGTON

   The States' Efforts at Medical Cost Containment

6. KEVIN HAUGH

   Twenty-four Hour Coverage

7. CHARLES R. BOOTH

   Overview of the Medicare Prospective Pay System

Presentation by: VIRGINIA MILLER, M.D.
Medical Director,
Office of Workers' Compensation Programs

OWCP'S MEDICAL COSTS AND CONTAINMENT INITIATIVES

Medical costs under the Federal Employees' Compensation Act (FECA) have grown precipitously over the past decade:

- $125.3 million in 1982 to $419.3 million in 1992.
- Between 1980 and 1990, medical costs under FECA quadrupled, and growth continues to accelerate.
- The mean increase since 1982 has exceeded 12.8%, compared to a 3.8% annual increase in the Consumer Price Index, and a 4.2% average annual COLA increase in wage loss compensation.
- The proportion of total FECA expenditures allocated for medical costs has grown from 14% in 1982 to 24.5% in 1992.

OWCP's provider population is very diverse and, in many instances physicians do not serve a large number of FECA claimants. For that reason, FECA does not have a major influence on treatment or billing patterns; instead, we are subject to external trends and the policies of Medicare, Medicaid, and state workers' compensation programs. Data from the Workers' Compensation Research Institute in Cambridge, Massachusetts, indicate that until 1980, the growth of the general health care costs and those covered under workers' compensation followed each other closely. After 1980, however, medical costs under compensation grew faster than general medical costs - - 14.7% for compensation and 9.8% for general. Our own data confirms this.

What is driving these increases? This question has been the topic of multiple discussions. In 1989, HHS Secretary Sullivan offered his views in testimony to the Medicare Long Term Care Subcommittee of the Senate Finance Committee. He attributed Medicare's increase to three factors:

Population	15%
Price	40%
Intensity and high technology	45%

We believe OWCP's experience is, at least in part, similar to Medicare's. To examine these issues, we examined FECA data in several ways. In particular, we wanted current data that would

help us to characterize the increase in medical costs, provide a focus for our efforts to devise additional cost containment strategies, and last but not least, establish a baseline to measure outcomes.

We looked at medical costs over the five year period from 1987 through 1992. Specifically, all cases for which we paid at least one medical service during the period July 1, 1987 through June 30, 1992 were included in the study. This population was then divided into two major groups: (1) Medical Benefits Only (MBO) group - - those with at least one or more paid medical service but NO compensation payments (these claimants could have used continuation of pay (COP), and (2) the Compensation Benefits group (COMP) - - those with at least one or more paid medical service, AND at least one or more compensation payment (the compensation payment could include a scheduled award).

Both major groups were subdivided into smaller subsets according to seven nature of injury (NOI) categories: (1) sprains and strains of all body parts, (2) fractures, (3) contusions, (4) lacerations, (5) mental/emotional illnesses, (6) unclassified traumatic injuries, and (7) all other injuries/illnesses, including occupational diseases. Medical costs ascribable to each category were identified and sorted into specific professional services to delineate the treatment patterns associated with each type of injury. To supplement these data, we compared medical costs for chargeback (CB) years 1987 and 1992 in terms of provider types.

The results of the study are contained in the graphs following this narrative. The major findings are summarized below:

- The total number of claimants has remained relatively stable over the 5-year period. While the number of cases in most NOI groups has remained stationary or actually decreased, the traumatic unclassified group shows significant increases, particularly in the MBO category. This may be an artefact due to coding practices.

- Although the number of claimants has been stable, the medical costs per case have increased in both major categories (MBO and COMP) The more salient increases in both categories are seen in the fractures, lacerations, and all other NOI groups. However, it should be noted that, across all NOI groups, the medical costs per case are significantly higher for claimants receiving medical and compensation benefits than for the MBO group.

- Although the overall medical costs reimbursed under the FECA have increased dramatically during the last decade, a comparison of CB 1987 and 1992, indicates that the per cent distribution by provider type has remained surprisingly stable. For example, in 1987, 86 per cent of the costs were associated with physician and hospital services, while the remaining 14 per cent were ascribed to pharmacies, supplies, rehabilitation and other providers. In 1992, physicians and hospitals accounted for 85 per cent of the costs and other providers were responsible for 15 per cent.

- When the treatment patterns for sprains and strains, lacerations, contusions, fractures and mental/emotional illnesses are examined, it is apparent that there are significant differences in the treatment patterns between these groups, as well as between the MBO and compensation benefits cases within a given nature of injury group. These are explained by the differences in the clinical history and severity of these conditions.

Obviously, these findings suggest that both price and intensity have played a role in the dramatic increase of FECA medical costs from 1987 to 1992.

OWCP is keenly aware of this problem and, over the past decade, has been quite active in its efforts to contain medical costs within the FECA program. For example:

- We have developed and are now field testing an enhancement to our medical bill processing system which will allow us to handle our bills in standardized fashion, improve our ability to monitor medical treatments and costs, and help us to apply selected cost containment techniques.

- In 1986, we established a fee schedule for the reimbursement of professional medical services (i.e. office visits, surgery, radiology), which was designed to contain extravagant and abusive charges. By regulation, we excluded hospitals, pharmacies and nursing homes. In May, 1991, we extended the fee schedule to some outpatient hospital charges. Currently, we are reducing about 7 per cent of the total billed dollars. It should be noted that this schedule uses relative value units (RVUs) to denote how much effort the service entails, a conversion factor to translate the RVUs into a dollar amount and a geographic modifier that adjusts payments according to the cost of delivering the service in the particular region. In its basic structure, the OWCP schedule resembles HCFA professional fee schedule.

- In the area of medical standards --

  OWCP has worked jointly with the National Institute for Occupational Safety and Health (NIOSH) and medical experts to better understand back injuries and define what constitutes appropriate treatment for these conditions. We have also worked with HHS's Agency for Health Care Research and their expert panel in the development of practice guidelines for low back disorders. We expect that these guidelines will be available to practicing physicians during this year. From these two efforts, we are expect to derive guidelines for the treatment of back injuries which we can use to monitor the care of our claimants.

- In the area of early medical management of injuries --

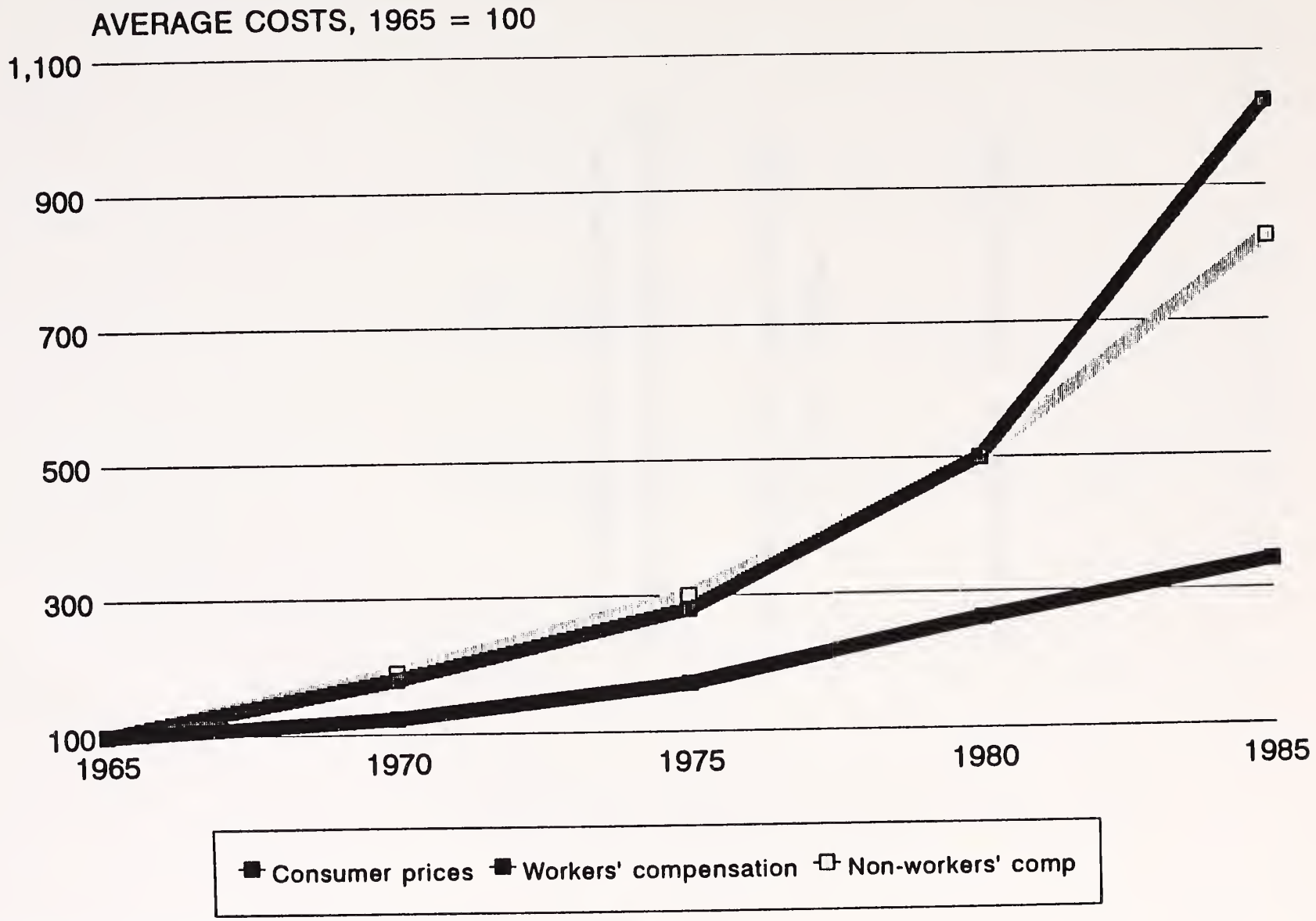
  In 1988, OWCP initiated a case controlled study of early intervention by nurses to improve the medical management of injuries resulting in long term or indeterminate disability. This study found that medical management was most effective where intervention began within 100 days of the injury. The probability of a return to work improved, time lost from work was reduced by 30 per cent and wage loss compensation was reduced by 30 per cent. However, first year medical expenses were not reduced because of the added expenses associated with the nurses' activities.

  In 1991, as part of the joint effort with NIOSH which began in 1987, OWCP initiated a study of early intervention in back cases. This study tested a structured, limited telephone intervention to monitor medical care and encourage the return to work. This effort is not yet completed, but preliminary indications from this and previous efforts have encouraged us to expand the use of nurses to conduct medical case management in our incoming cases.

  We have initiated the use of medical matrices to identify intervention points in cases where the length of disability exceeds the norm. In addition, in several district offices, we are conducting a periodic roll review and the need for continuing medical care is being assessed as part of this review.

- We maintain contact with the Health Care Financing Administration (HCFA) and other agencies to learn new concepts in case management, cost containment, medical bill processing, etc. We have studied HCFA's new fee schedule and intend to adopt at least part of it in the near future; we are looking into the electronic transmission of bills to expedite and simplify our bill processing.

Trends in U.S. Medical Costs:
Workers' Compensation Versus Non-workers' Compensation



Ref.: Workers' Compensation Research Institute Report WC-89-5

FEDERAL EMPLOYEES' COMPENSATION ACT

MEDICAL COST DATA

CHARGEBACK YEARS 1972 THROUGH 1992

FIVE-YEAR STUDY STATISTICAL ANALYSES

CHARGEBACK YEARS 1987 THROUGH 1992

U.S. DEPARTMENT OF LABOR
CHARGEBACK COSTS UNDER FECA 1972 THROUGH 1992

(In Millions)

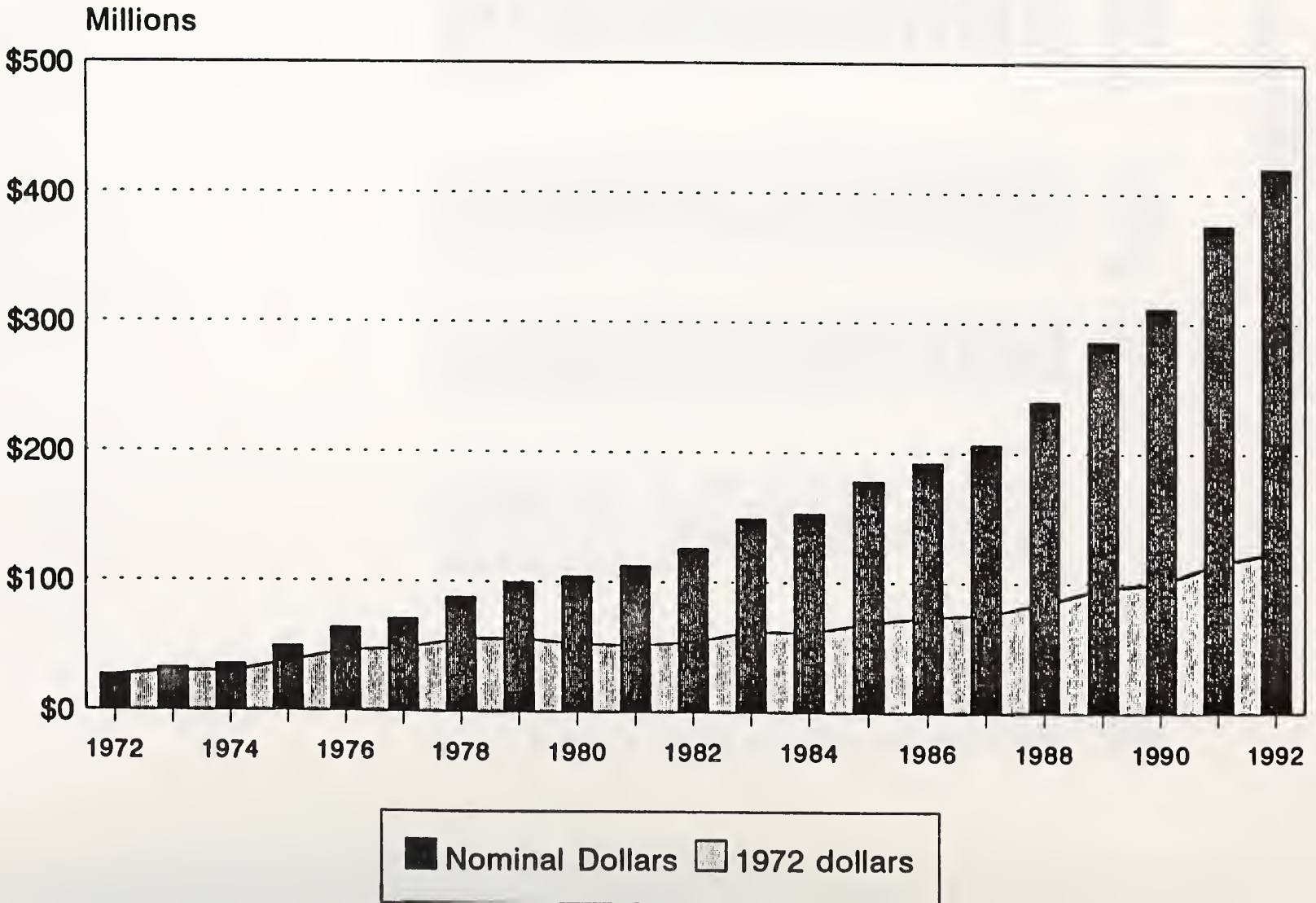
CB YEAR	TOTAL DOLLARS	MEDICAL DOLLARS	% MED $ OF TOTAL	COMP DOLLARS	% COMP $ OF TOTAL
72	$190.0	$26.9	14.16%	$163.1	85.84%
73	$217.7	$32.3	14.84%	$185.4	85.16%
74	$270.6	$35.2	13.01%	$235.4	86.99%
75	$367.5	$48.9	13.31%	$318.6	86.69%
76	$477.2	$63.3	13.26%	$413.9	86.74%
77	$552.1	$70.5	12.77%	$481.6	87.23%
78	$626.4	$87.3	13.94%	$539.1	86.06%
79	$700.0	$98.7	14.10%	$601.3	85.90%
80	$784.8	$103.4	13.18%	$681.4	86.82%
81	$849.0	$111.7	13.16%	$737.3	86.84%
82	$885.7	$125.3	14.15%	$760.4	85.85%
83	$918.6	$148.1	16.12%	$770.5	83.88%
84	$939.9	$152.0	16.17%	$787.9	83.83%
85	$1,026.5	$177.2	17.26%	$849.3	82.74%
86	$1,111.4	$191.7	17.25%	$919.7	82.75%
87	$1,127.7	$205.8	18.25%	$921.9	81.75%
88	$1,199.7	$238.7	19.90%	$961.0	80.10%
89	$1,328.0	$285.3	21.48%	$1,042.7	78.52%
90	$1,498.6	$311.2	20.77%	$1,187.4	79.23%
91	$1,573.4	$375.3	23.85%	$1,198.1	76.15%
92	$1,719.7	$419.3	24.38%	$1,300.4	75.62%

02/16/93

GROWTH IN MEDICAL COSTS UNDER FECA

CB 1972 -- CB 1992

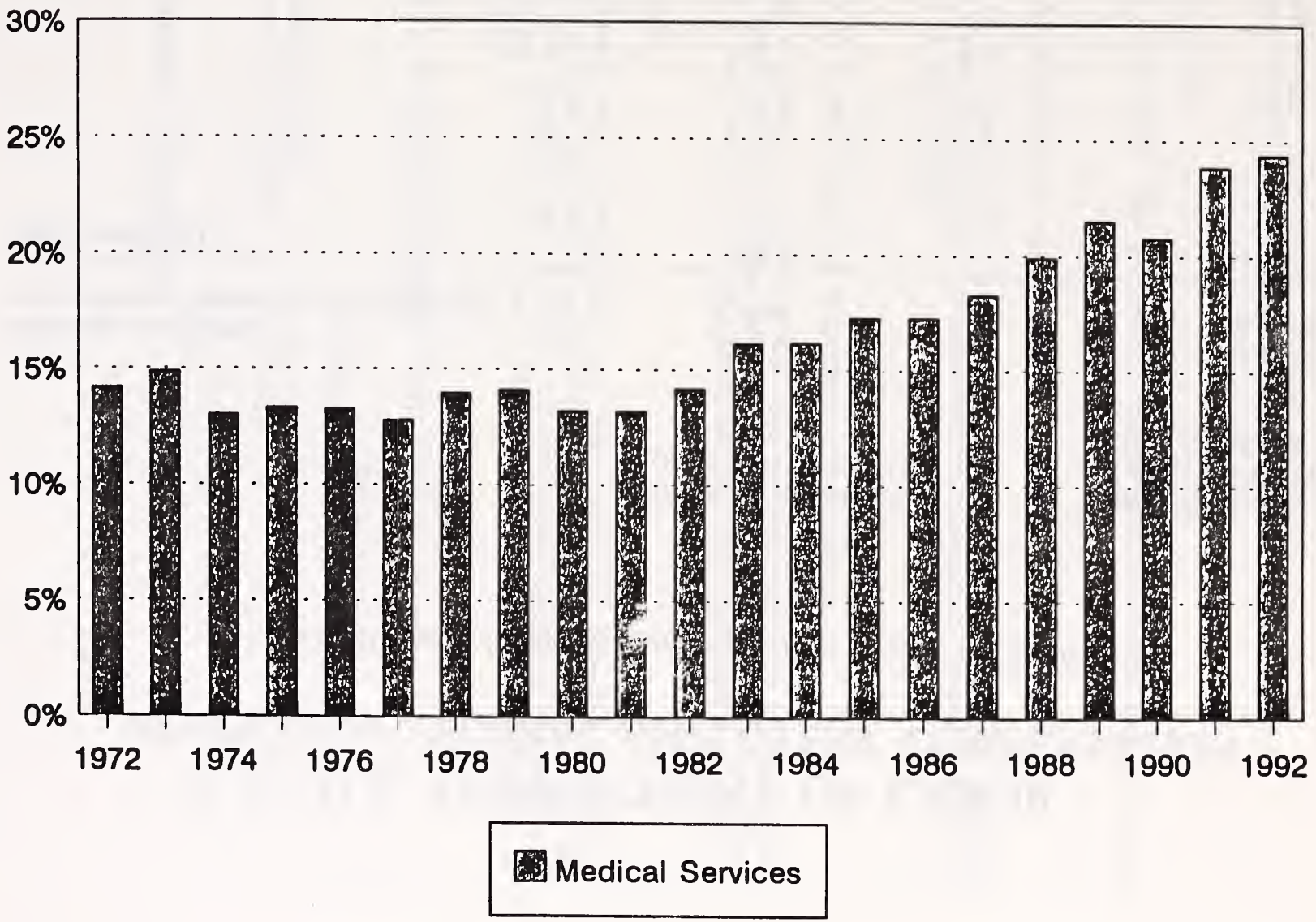
Nominal and Constant (1972) Dollars



DISTRIBUTION OF COSTS UNDER FECA

MEDICAL SHARE OF ALL BENEFIT DOLLARS

CB 1972 -- CB 1992



U.S. DEPARTMENT OF LABOR
DIVISION OF FEDERAL EMPLOYEES' COMPENSATION

Medical Fee Schedule Reductions Under FECA -- CB 1992

	REDUCED AMOUNT AS PROPORTION OF TOTAL PAID	REDUCED AMOUNT AS PROPORTION OF TOTAL PAID UNDER F.S. *
HOSPITAL OUTPATIENT	1.78 %	2.83 %
PROFESSIONAL SERVICES - FEE SCHEDULE	5.20 %	8.28 %
TOTAL REDUCED	6.98 %	11.11 %

* These totals include hospital outpatient services without maxima assigned such as charges for use of the Emergency Room, Recovery Room, etc.

FIVE YEAR STUDY
CHARGEBACK YEARS 1988 THROUGH 1992

CASE SELECTION:

All claimants had at least one medical service billed under FECA.

MEDICAL BENEFITS ONLY CLAIMANTS:

Those claimants with at least one medical service but without any wage replacement (compensation) payments during the five-year study period.

CLAIMANTS WITH MEDICAL AND COMPENSATION BENEFITS:

Those claimants with at least one medical service and at least one compensation (wage replacement) payment during the five-year study period. COP benefits are not included in totals.

YEARLY COSTS:

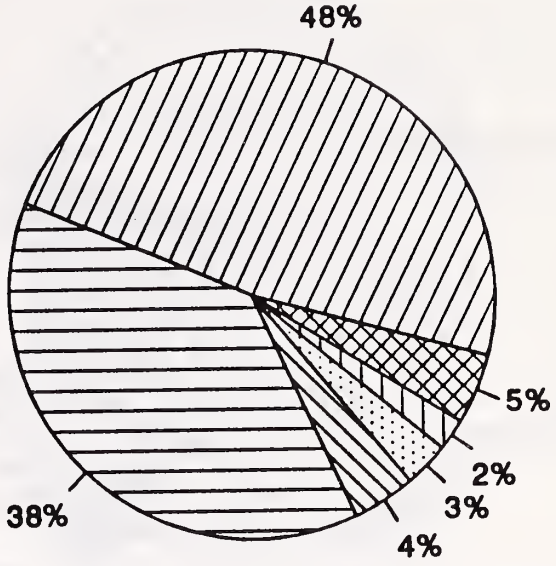
Claimants are categorized by date medical service occurred (i.e. costs for all claimants with a medical service in CB 1991 are counted in CB 1991; if the same claimant had medical services in CB 1992, costs for those services are counted in CB 1992).

POPULATION - FIVE-YEAR STUDY CB 1988 THROUGH CB 1992

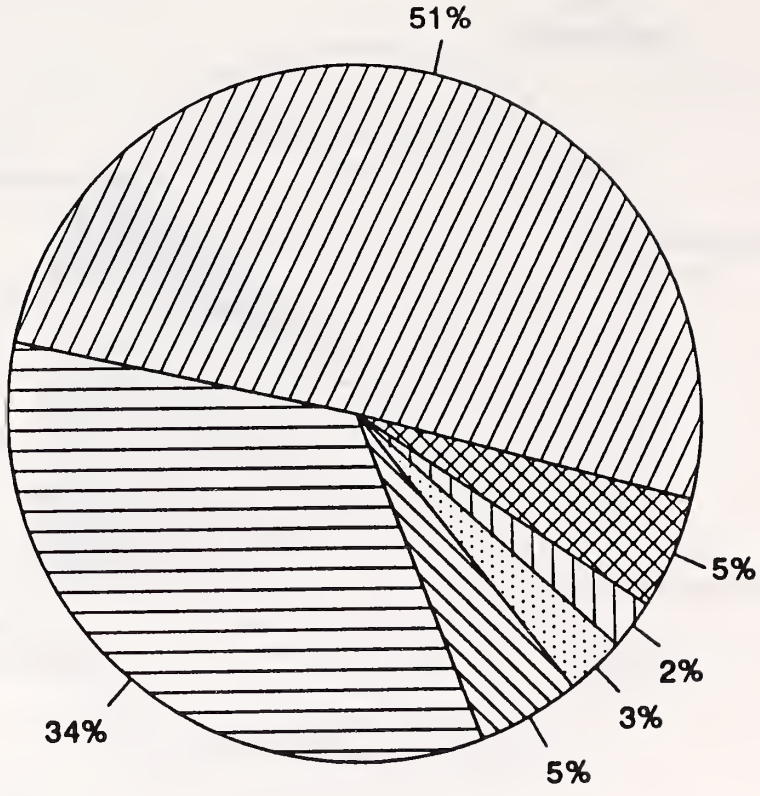
Category	Total Numbers Females	Males	Total
Medical Benefits Only	197,894	394,938	592,832
Compensation and Medical	39,423	79,737	119,160
Total*	237,317	474,675	711,992

* All claimants counted once.

MEDICAL COSTS UNDER FECA
DISTRIBUTION BY PROVIDER TYPE



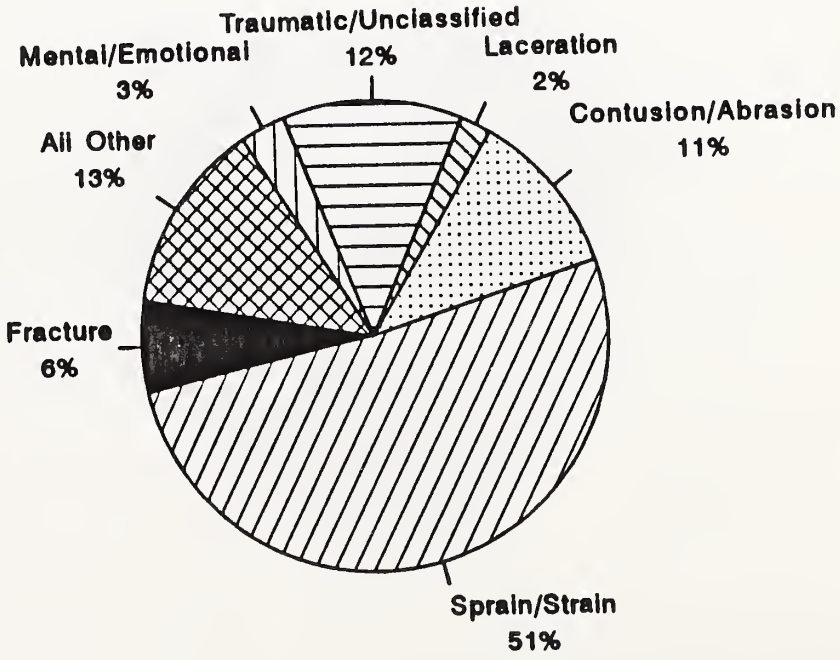
CB 1987



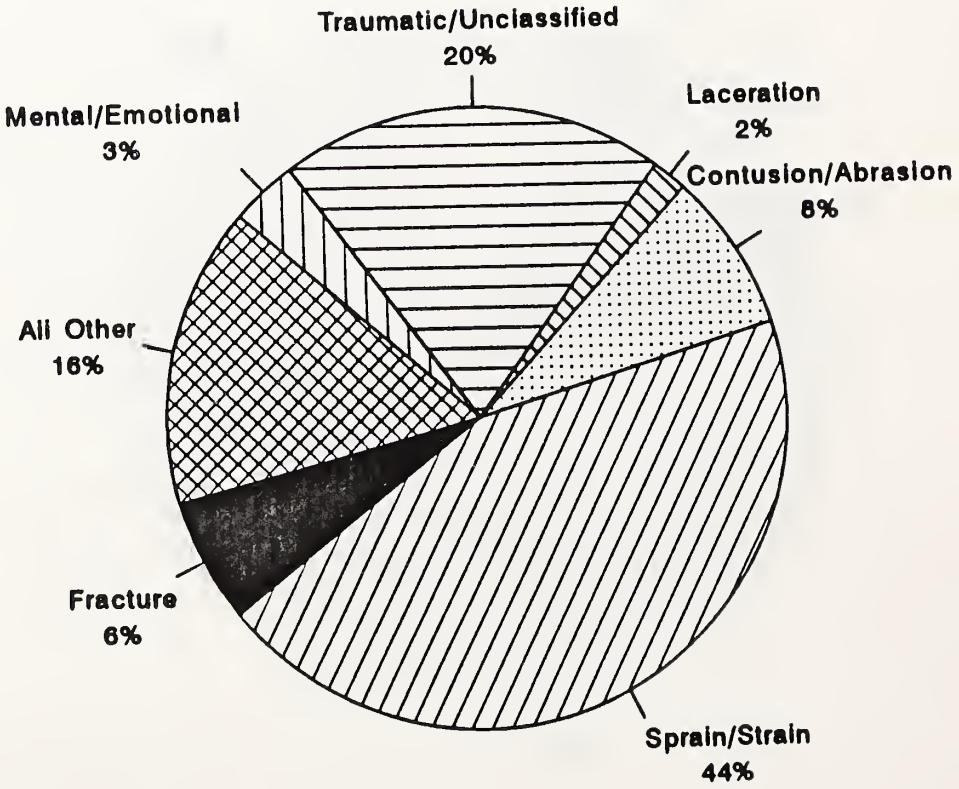
CB 1992

Prof. Med. Serv. | Hospital | Pharmacy
Rehabilitation | Supplies | Other Serv.

MEDICAL COSTS UNDER FECA
DISTRIBUTION BY NATURE OF INJURY
All Claimants

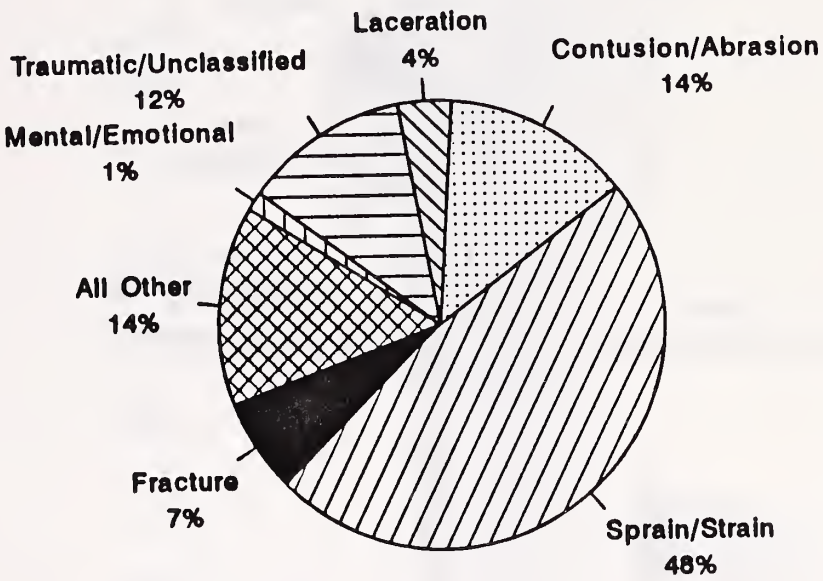


CB 1988

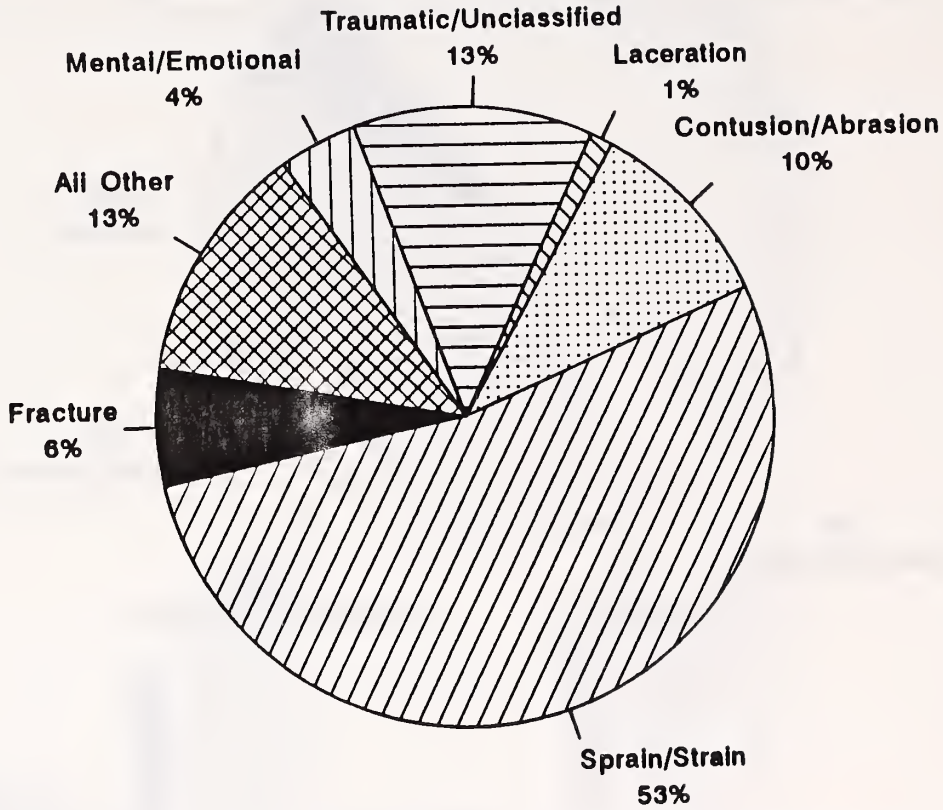


CB 1992

MEDICAL COSTS UNDER FECA
DISTRIBUTION BY NATURE OF INJURY
CB 1988

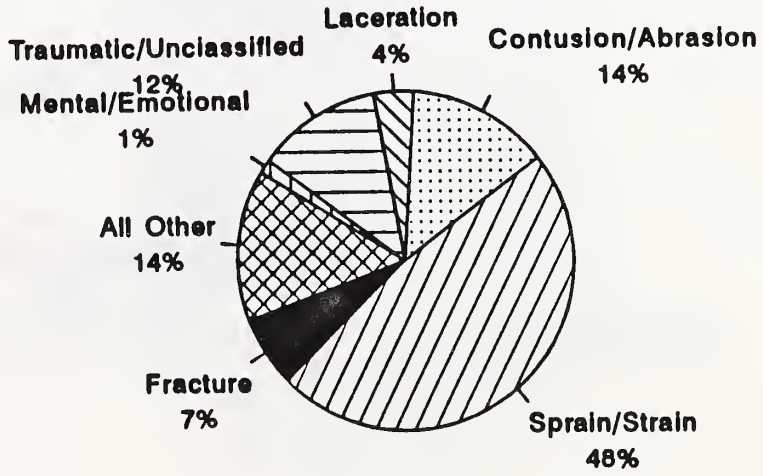


Claimants w/Medical Benefits Only

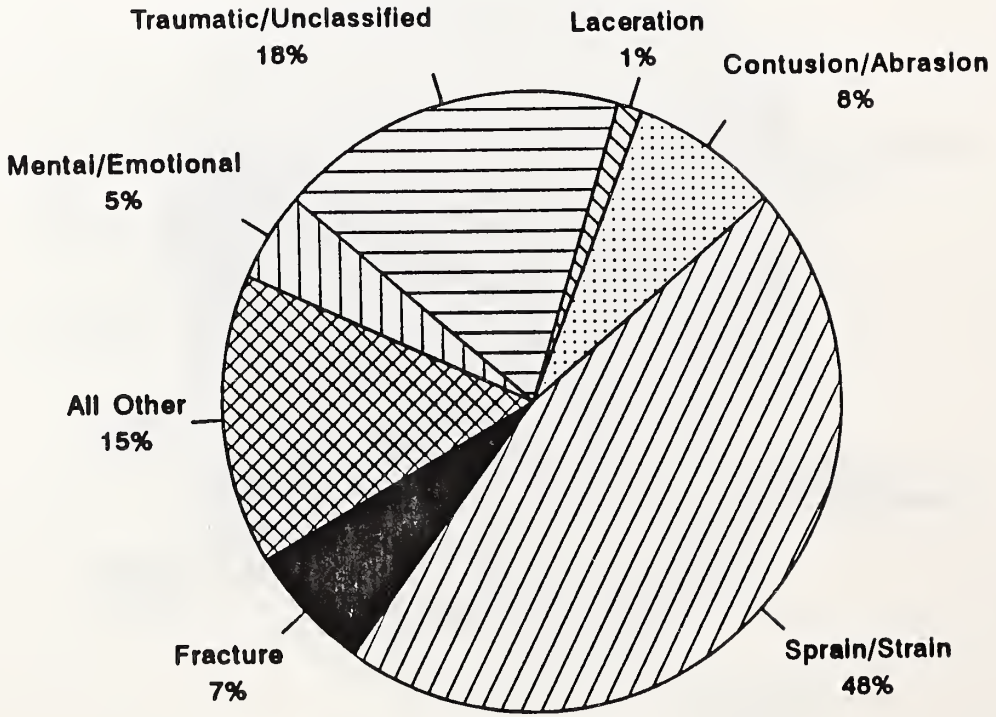


Claimants w/Comp & Medical Benefits

MEDICAL COSTS UNDER FECA
DISTRIBUTION BY NATURE OF INJURY
CB 1992



Claimants w/Medical Benefits Only

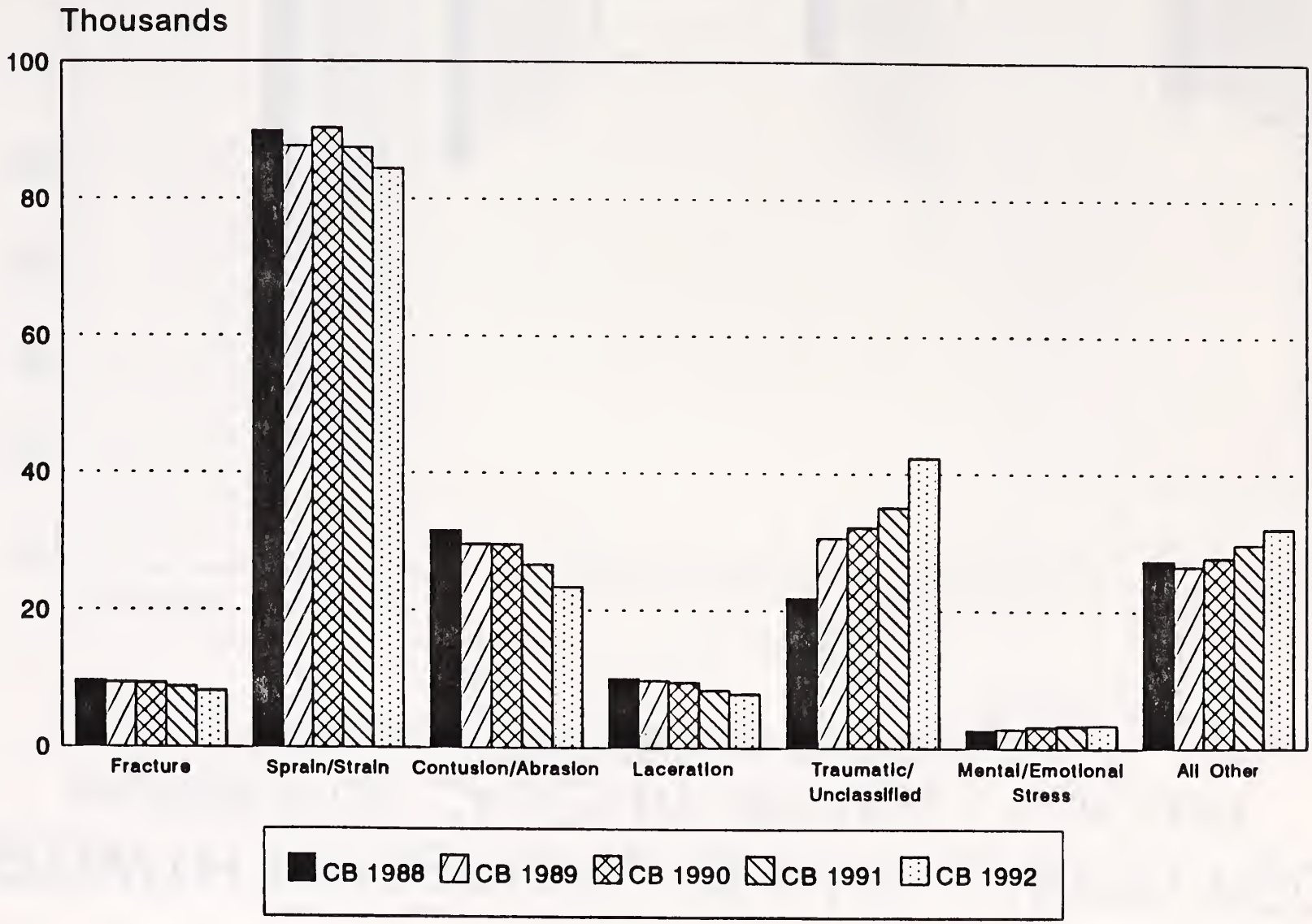


Claimants w/Comp & Medical Benefits

GROWTH IN MEDICAL CLAIMS UNDER FECA

NUMBER OF CASES BY NATURE OF INJURY

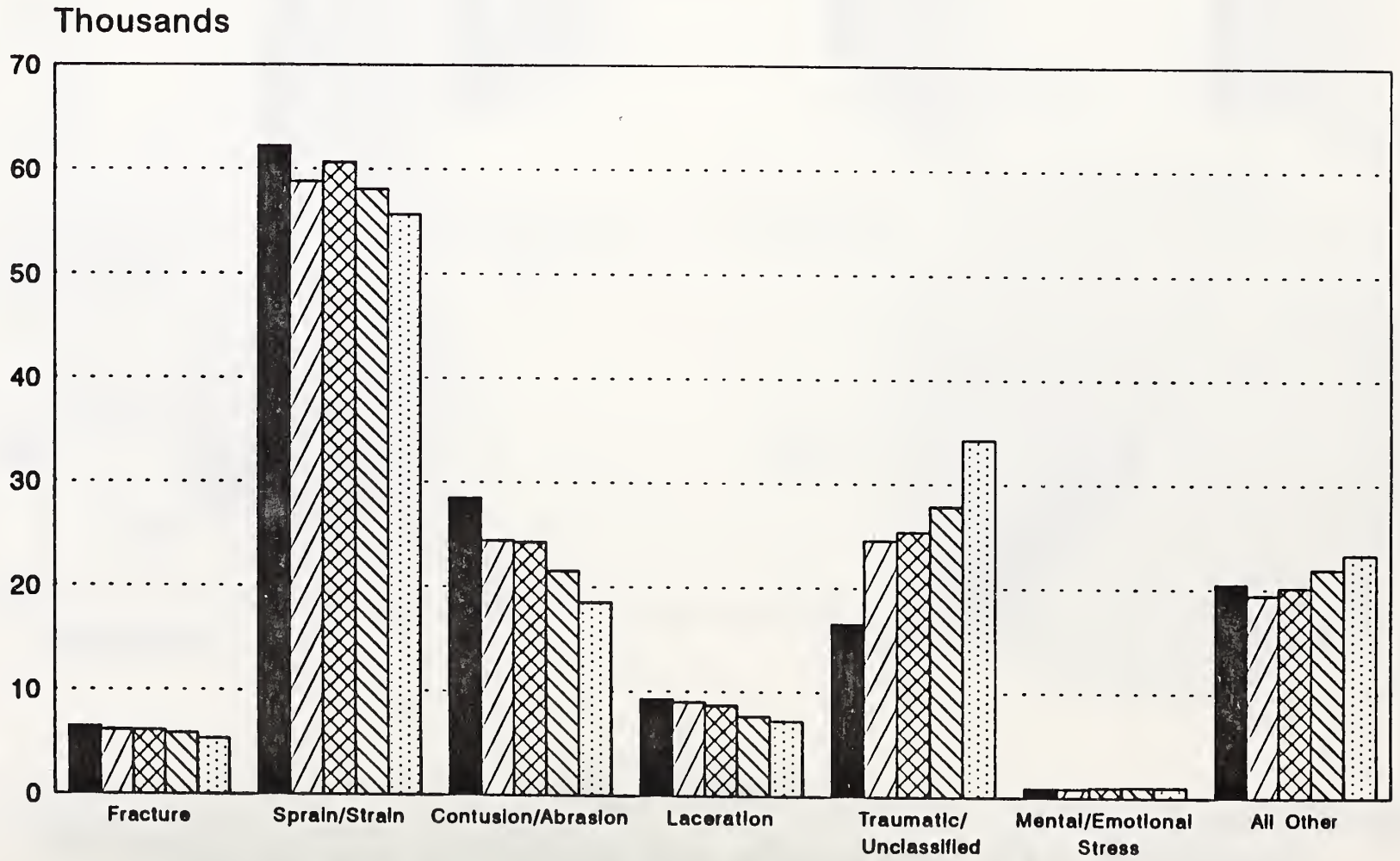
All Cases



GROWTH IN MEDICAL CLAIMS UNDER FECA

NUMBER OF CASES BY NATURE OF INJURY

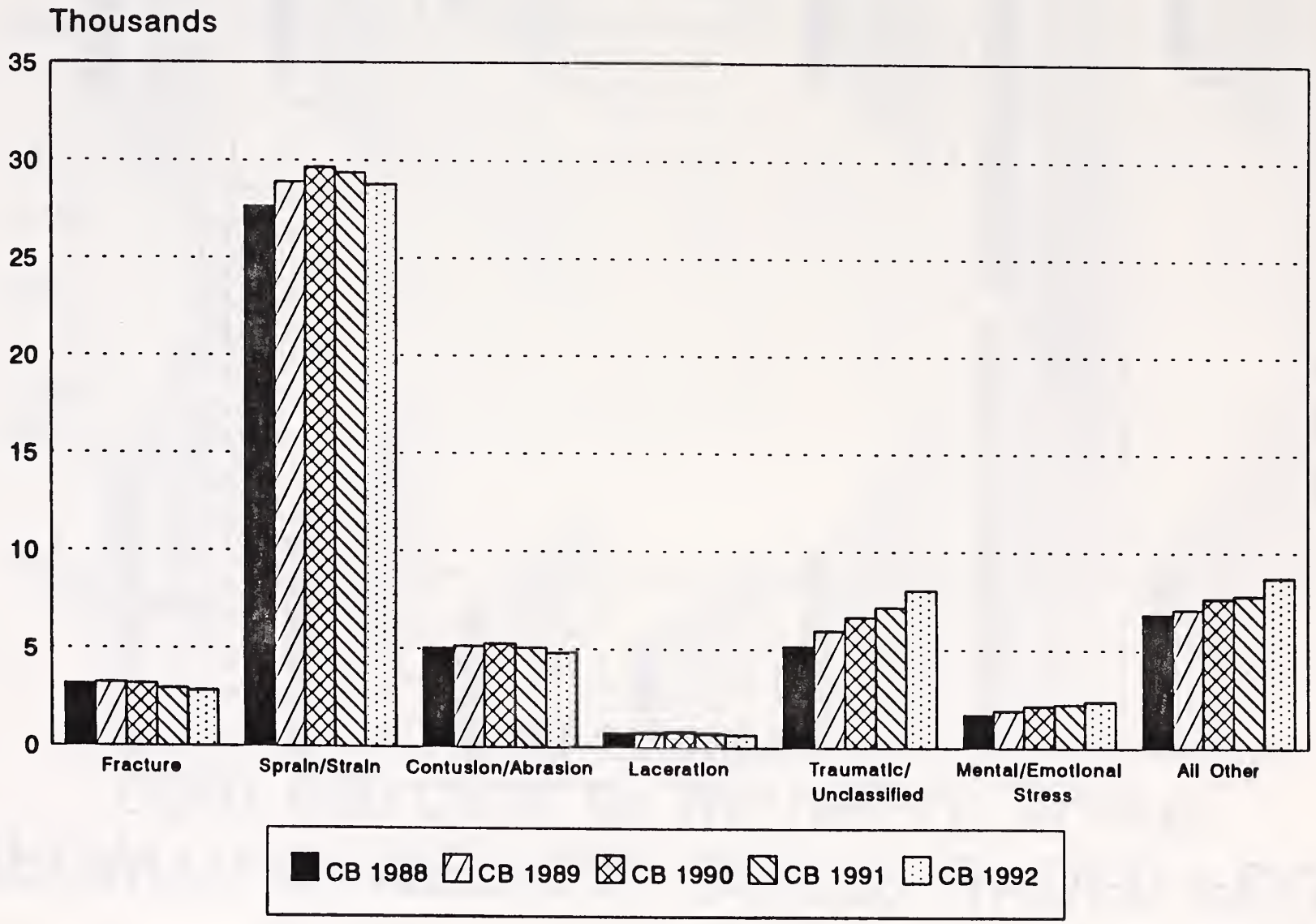
Claimants with Medical Benefits Only



GROWTH IN MEDICAL CLAIMS UNDER FECA

NUMBER OF CASES BY NATURE OF INJURY

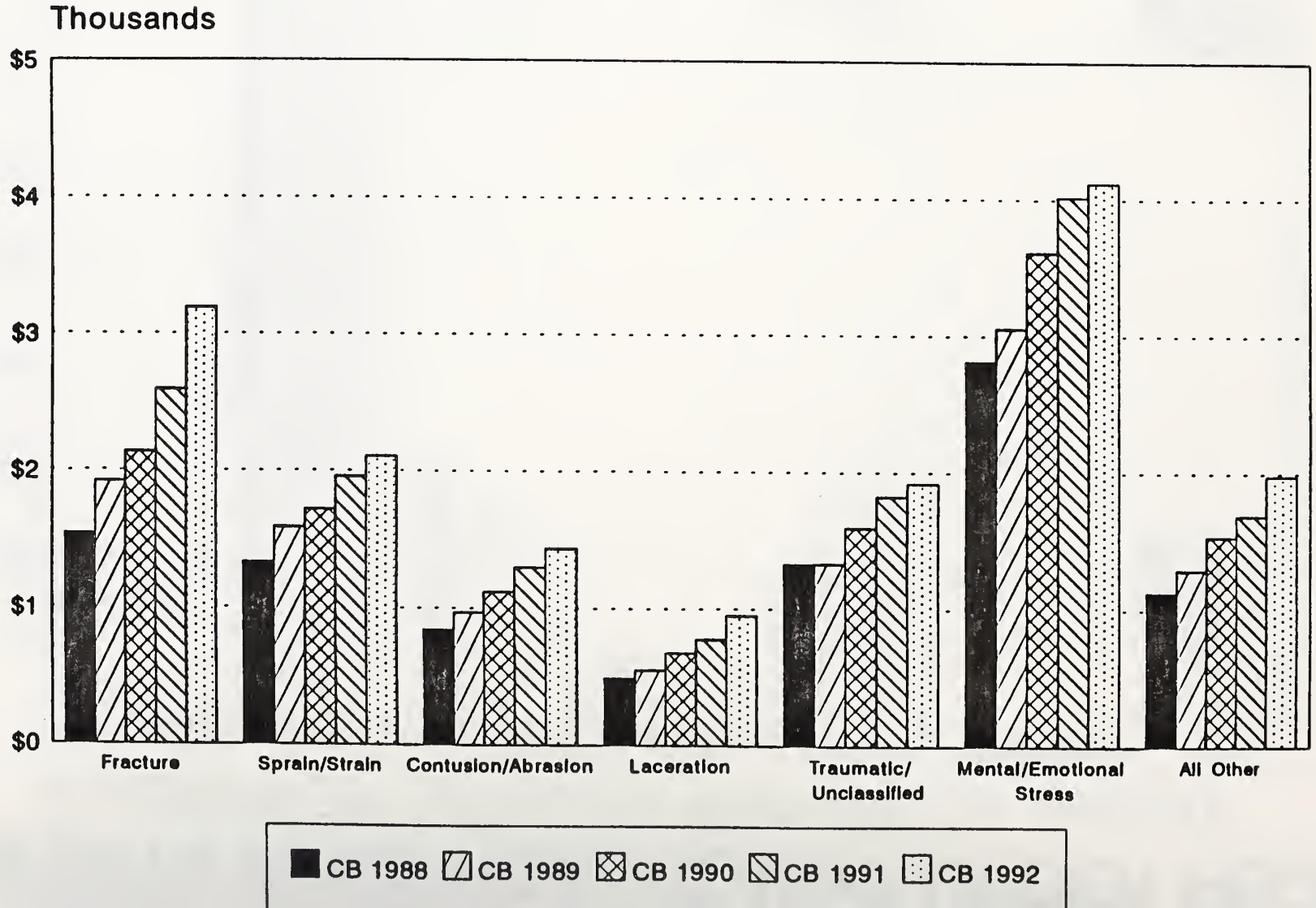
Claimants with Medical and Comp Benefits



GROWTH IN MEDICAL COSTS UNDER FECA

COST PER CASE BY NATURE OF INJURY

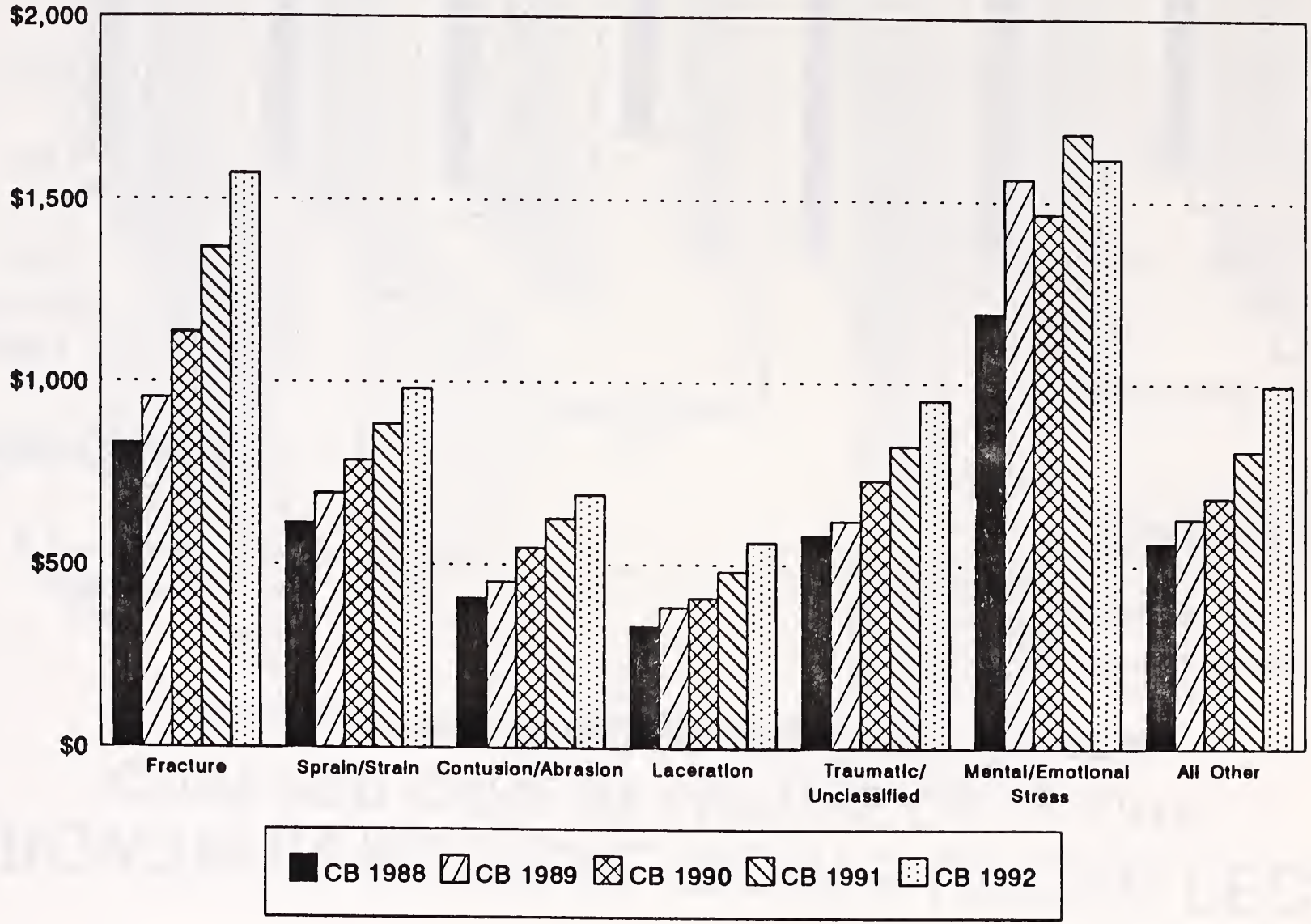
All Claimants



GROWTH IN MEDICAL COSTS UNDER FECA

COST PER CASE BY NATURE OF INJURY

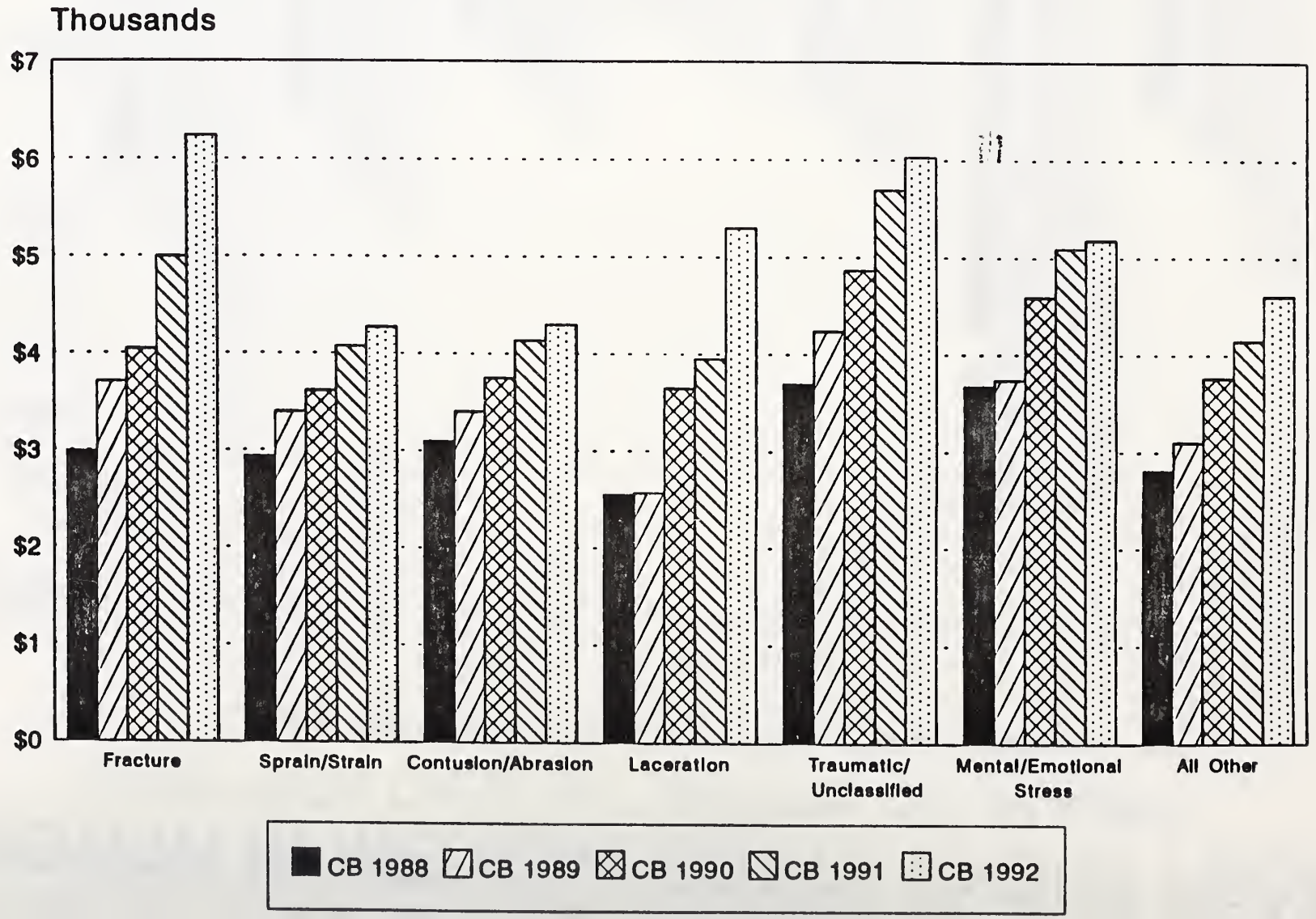
Claimants with Medical Benefits Only



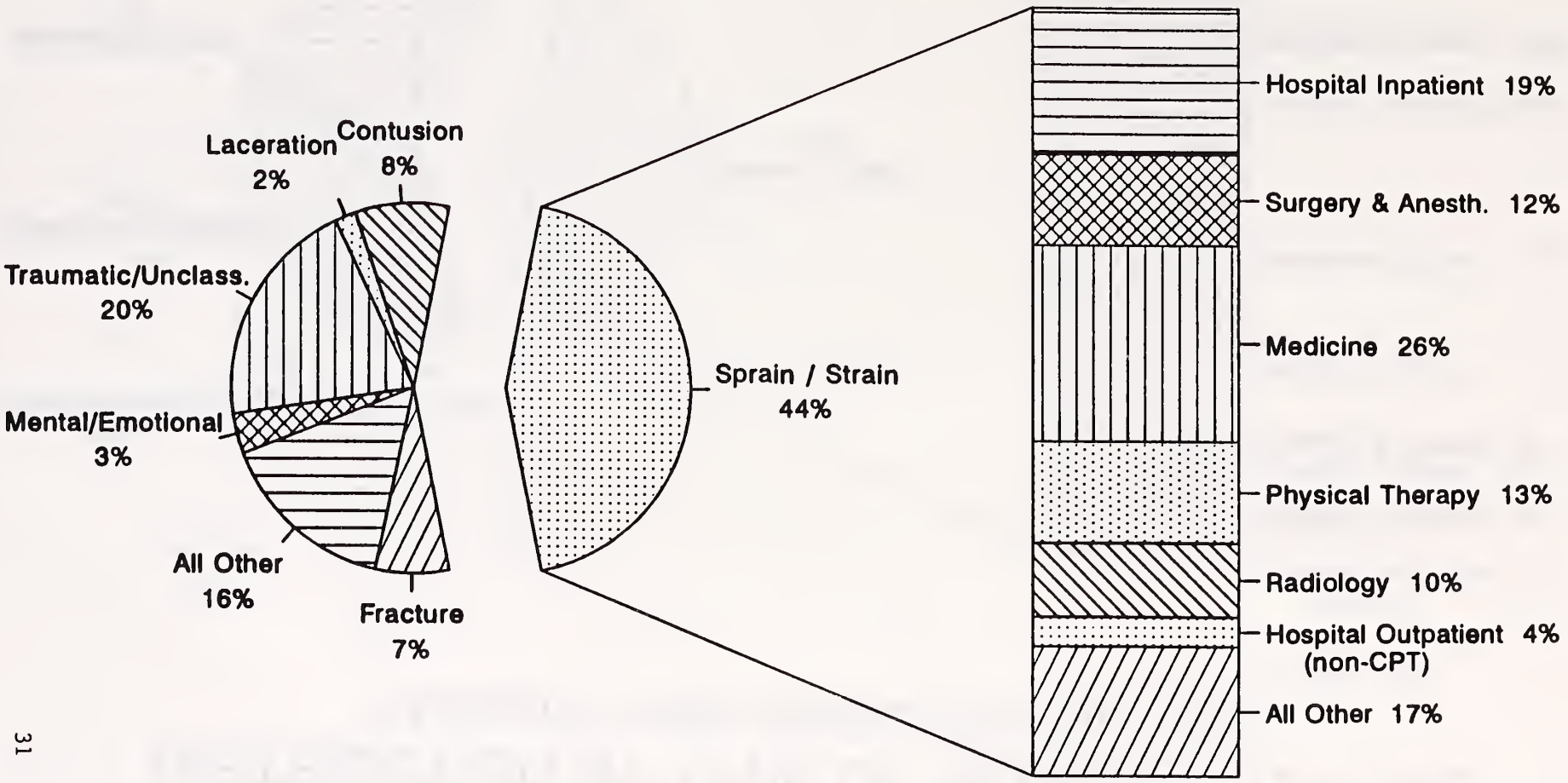
GROWTH IN MEDICAL COSTS UNDER FECA

COST PER CASE BY NATURE OF INJURY

Claimants with Medical and Comp Benefits



MEDICAL COSTS UNDER FECA
DISTRIBUTION BY TYPE OF SERVICE - CB 1992
All Claimants



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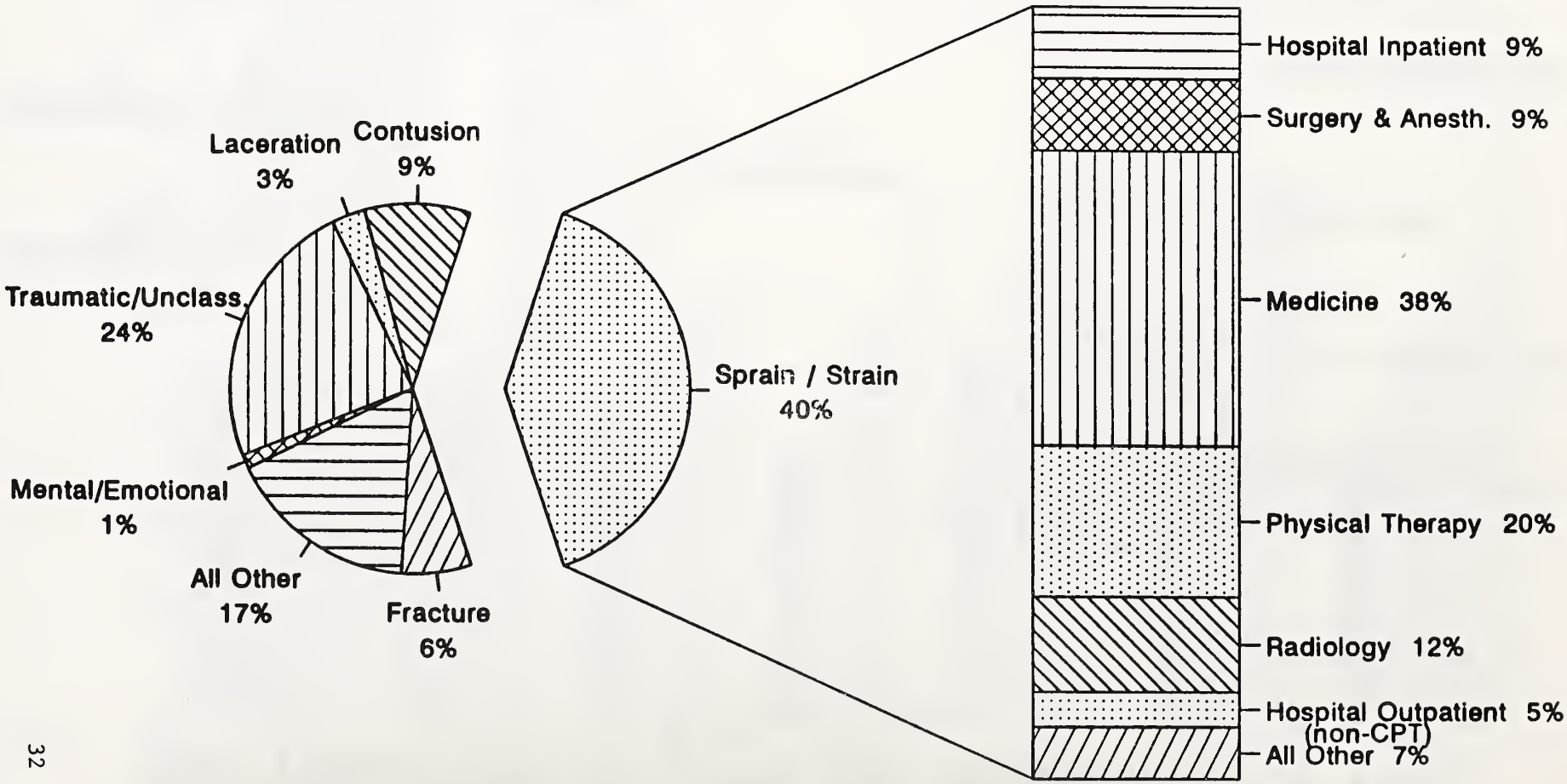

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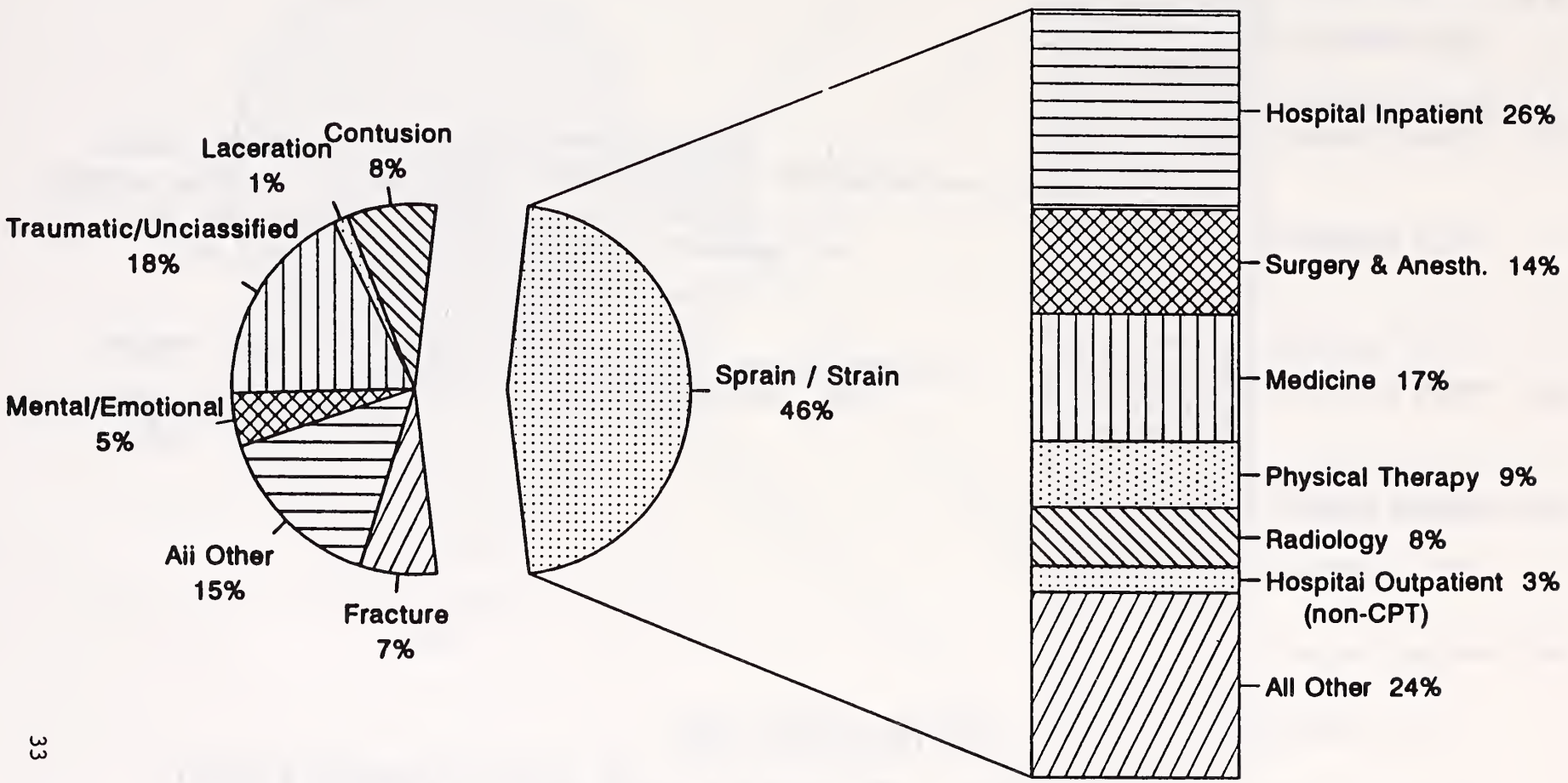

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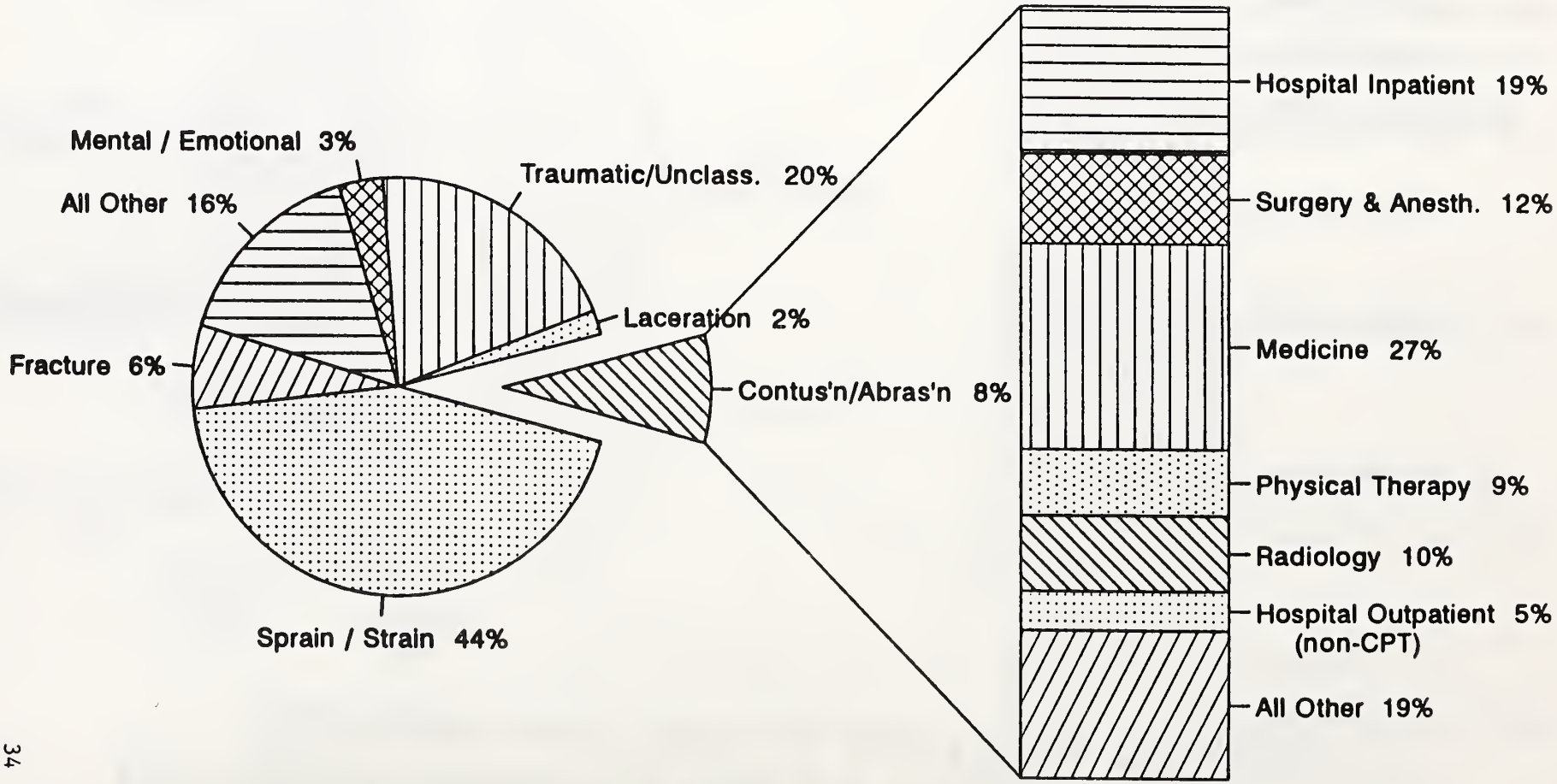

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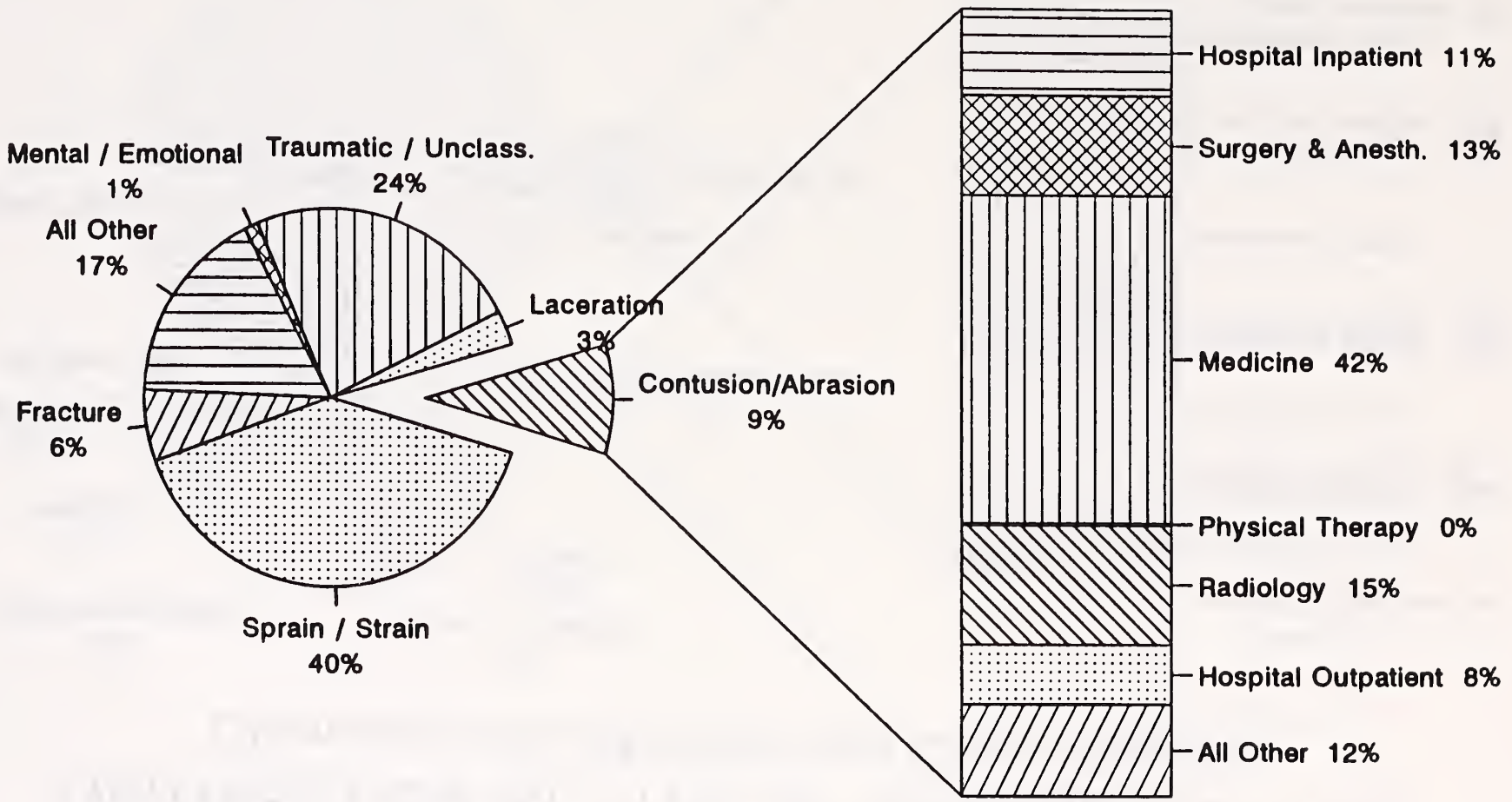

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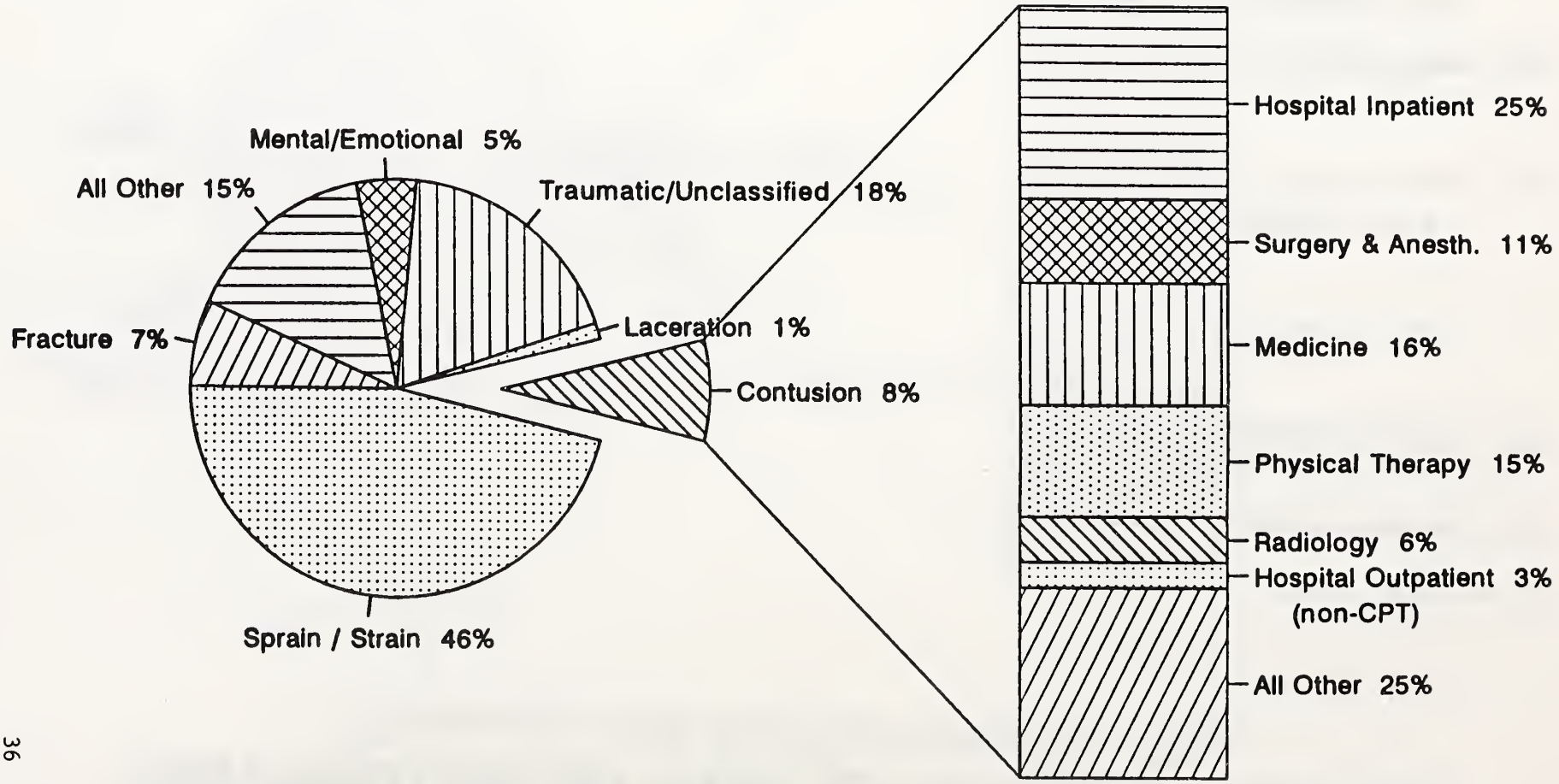

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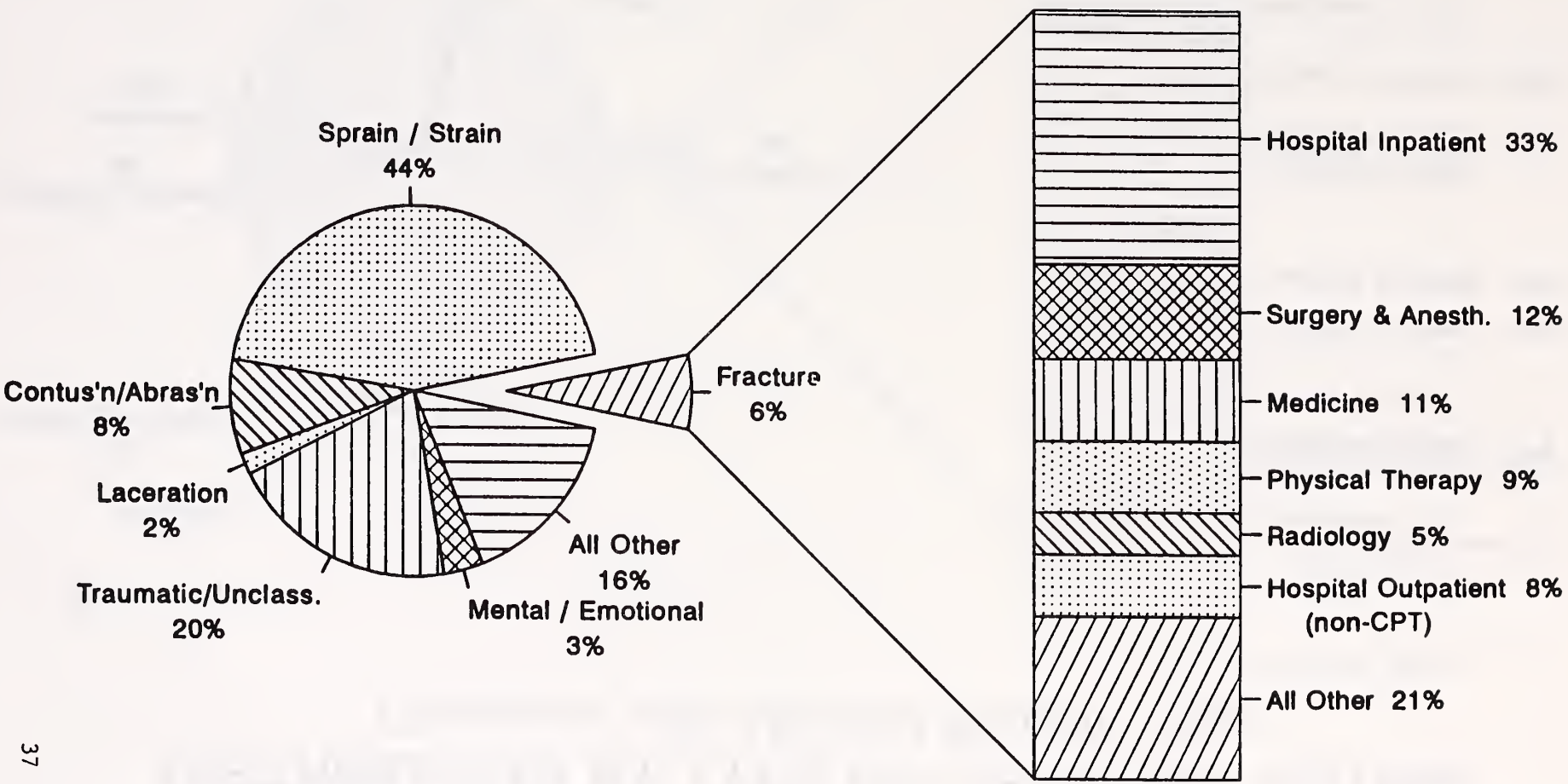

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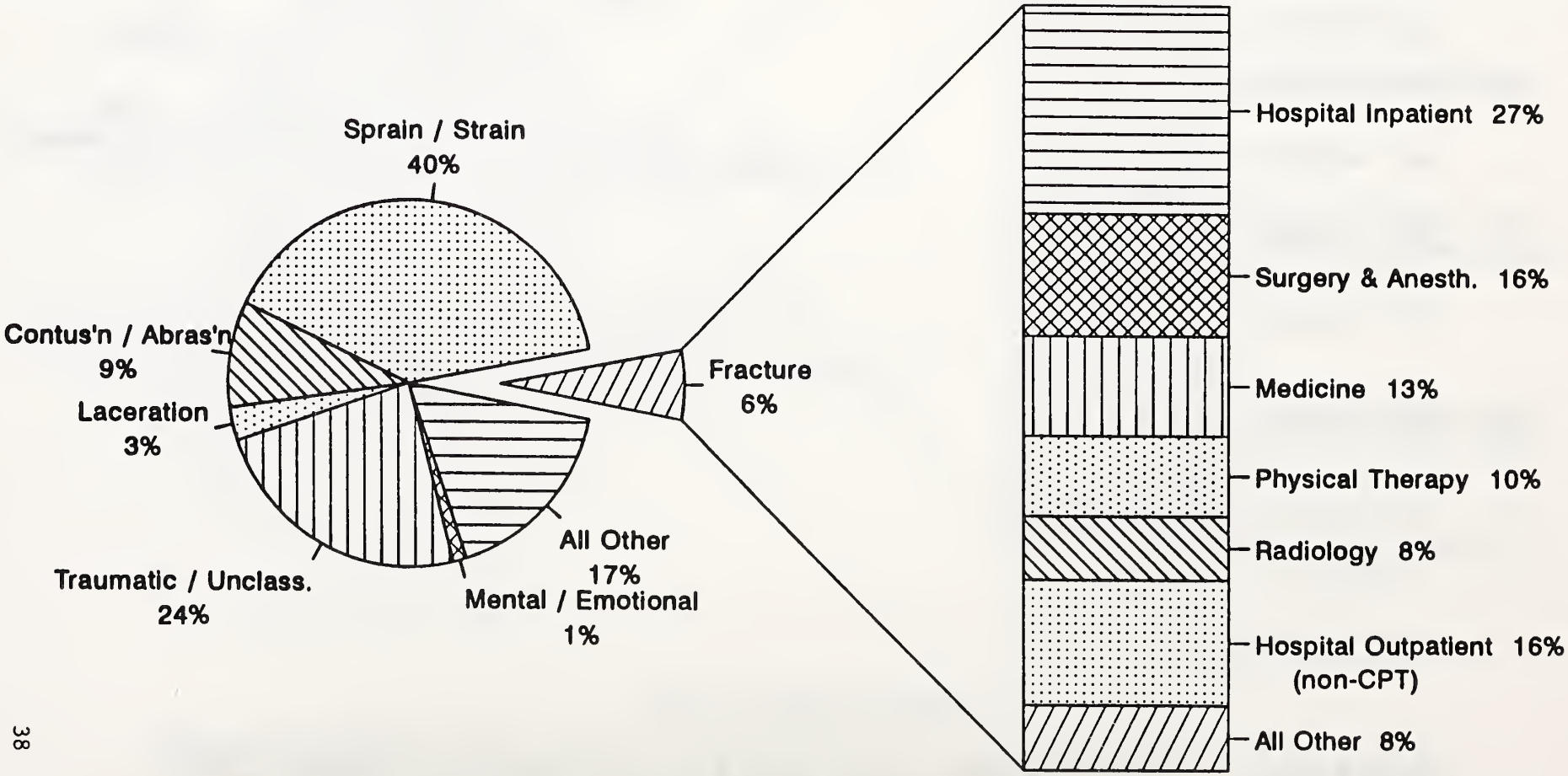

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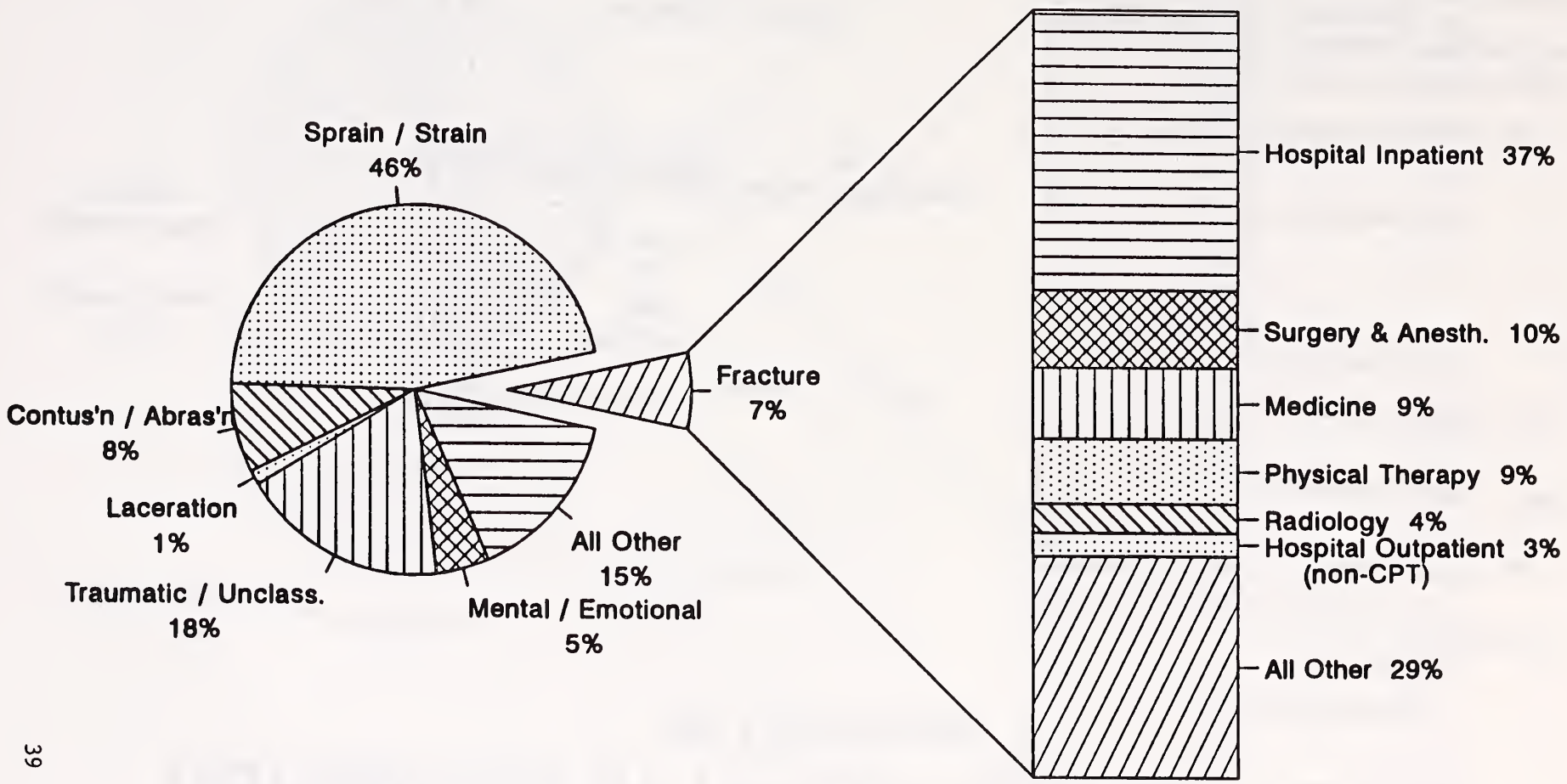

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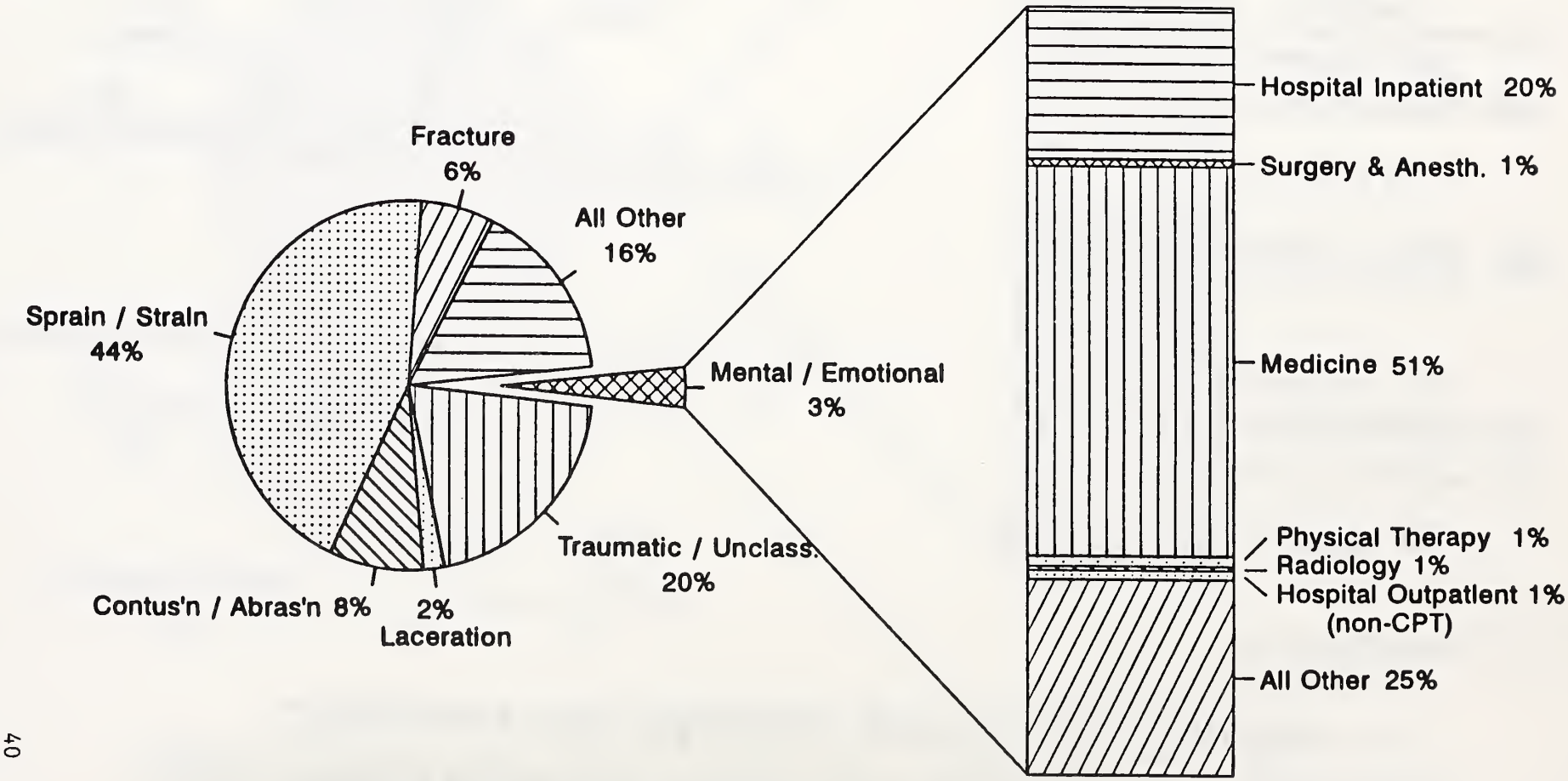

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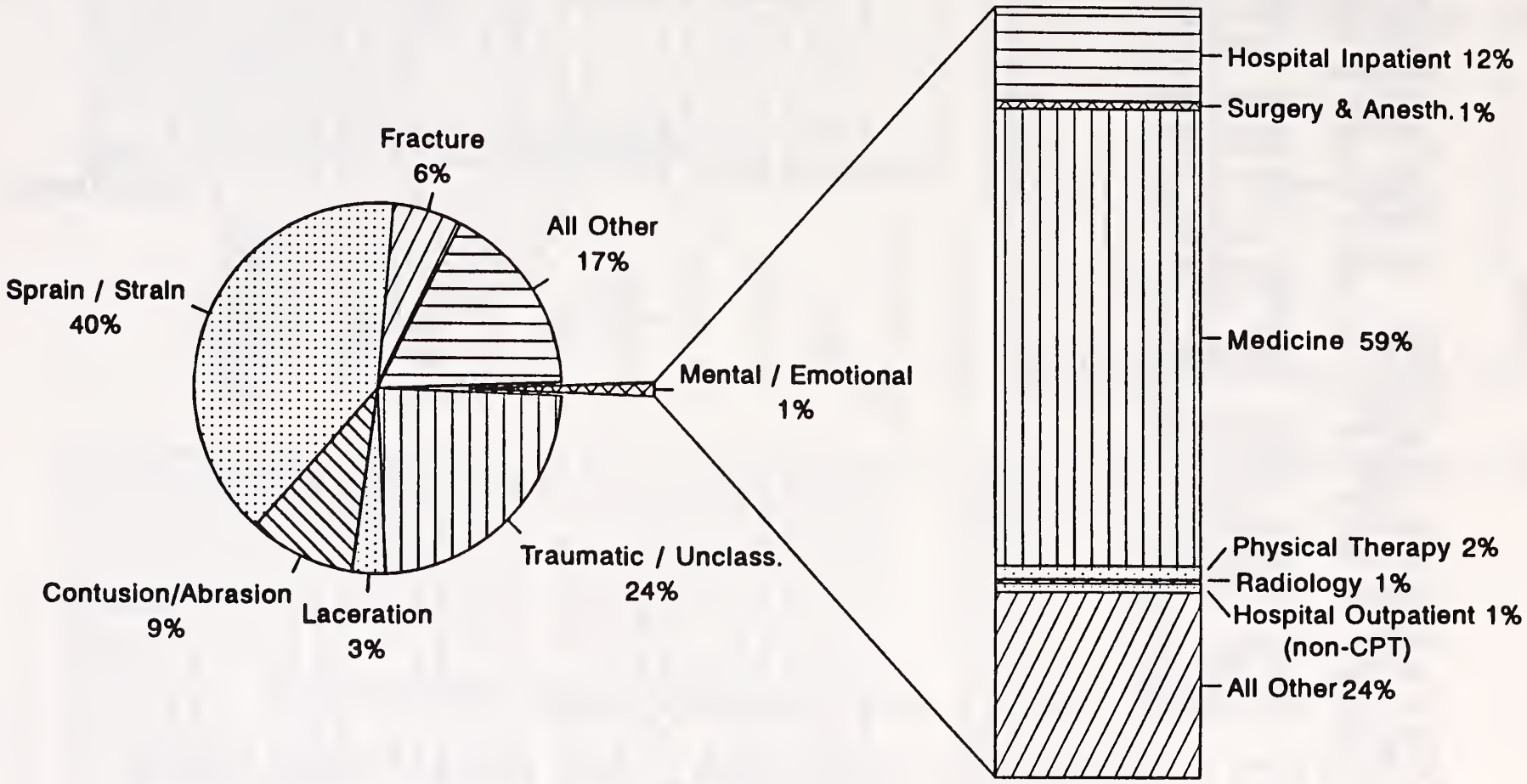

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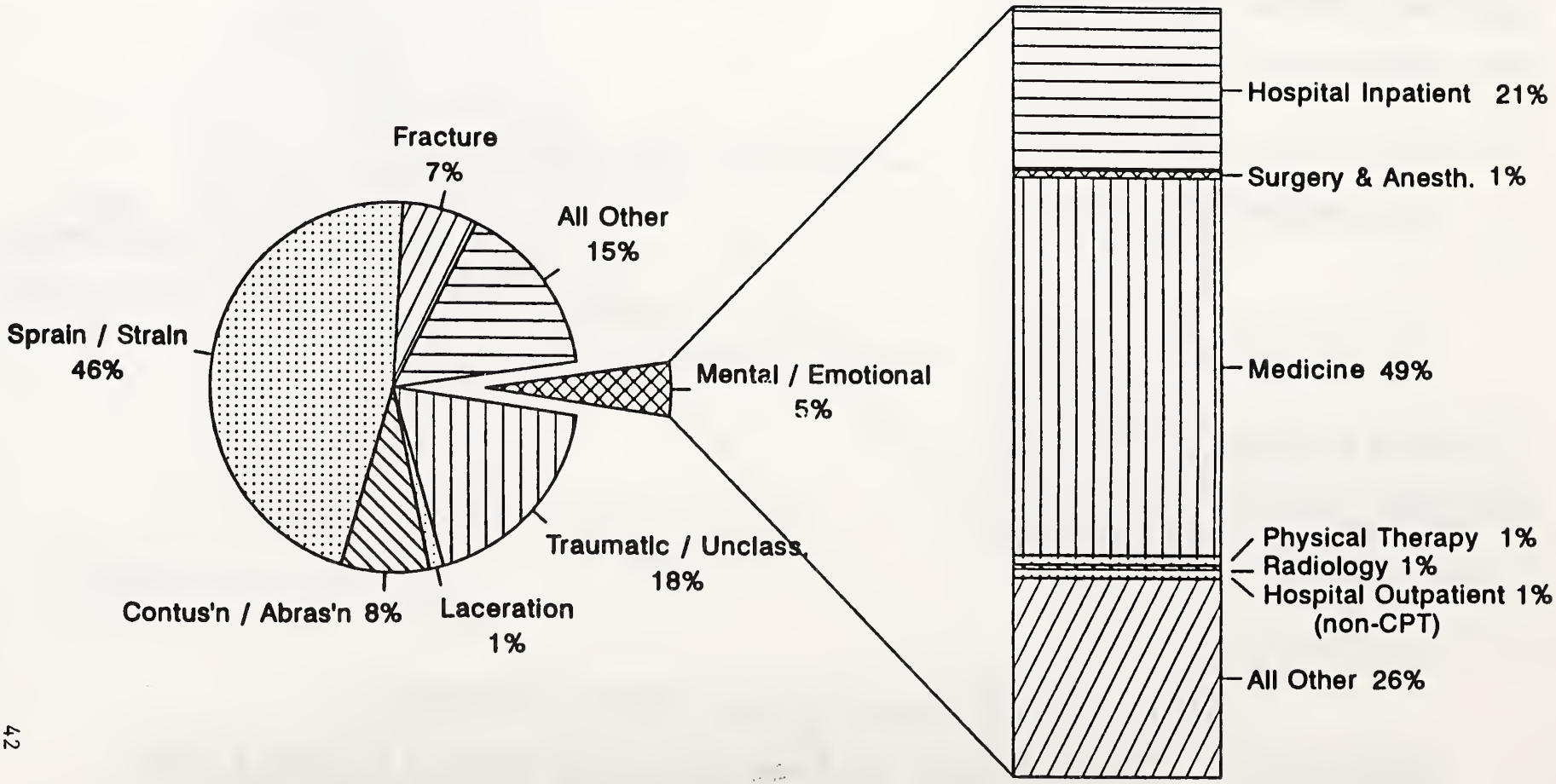

PRESENTATION BY:
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HHS

SPECIAL SECTION

CLINICAL PRACTICE GUIDELINES

The Agency For Health Care Policy And Research Fosters the Development Of Evidence-Based Guidelines

BY KATHLEEN A. McCORMICK, PhD, RN, & BARBARA FLEMING, MD, PhD

Medicine . . . is mobile, and many of us get breathless not so much by trying to keep up with medical progress as by trying to avoid being run over by it.

—Roger I. Lee (1958)[1]

Roger Lee's observation on the runaway nature of medical progress is even truer today. Currently, the National Library of Medicine processes more than 33,000 articles each month. D. T. Durack comments that the growth of medical knowledge can be measured by the weight of medical textbooks and the numbers being produced.[2] The increasing complexity and rapid growth of medical science and technology have been major stimuli for the development of clinical practice guidelines as providers, payers, and regulators attempt to assess current practices and integrate new knowledge and technology.

Most health policy analysts cite three factors as providing today's impetus for guideline development:

- Practice pattern variations
- Concern with inappropriateness of care
- High healthcare costs

Uncertainties about the extent of inappropriate and unnecessary care have arisen from studies that began to appear in the late 1970s examining practice variations and discrepancies. Studies on the use of cardiac pacemakers, carotid endarterectomy, coronary artery bypass surgery, coronary angiography, and upper gastrointestinal endoscopy support the belief that medical practices vary widely and should be made more uniform.

Dr. McCormick is director, Office of the Forum for Quality and Effectiveness in Health Care, Department of Health and Human Services, Rockville, MD; and Dr. Fleming is senior health policy analyst, Agency for Health Care Policy and Research, Department of Health and Human Services.

Summary As medical technology increases rapidly and becomes more complex, clinical practice guidelines can help healthcare providers assess current practices and integrate technological advances. Through the Agency for Health Care Policy and Research (AHCPR), the federal government has begun to facilitate the development of clinical practice guidelines.

Expert or contract panels, authorized by the AHCPR, develop guidelines on specific clinical conditions. The AHCPR guideline methodology is designed to produce evidence-based guidelines that are valid, clinically applicable, and clinically flexible.

Each panel spends a year or more developing the guideline, beginning with an extensive literature search and review. The panel prepares evidence tables, statistically analyzes aggregate data (where appropriate), conducts harm and benefit analyses, and prepares health policy analyses (or cost-impact studies).

During this process, the panel holds an open forum to solicit comments on the guideline topic. After this public discussion, the panel prepares a final draft of the guideline. Several hundred individuals review the guideline.

Some policymakers believe clinical practice guidelines can lead to better healthcare outcomes. Guidelines can provide information in a useful format for clinicians to use at the bedside or the point of decision making in patient care. Guidelines also provide information that can be used in continuing education and professional education programs.

For example, the small-area variation analyses of John E. Wennberg showed substantial differences in per capita utilization and costs for a variety of procedures and practices across hospital market areas, even after adjustment for differences in patient age and sex.[3] Wennberg found a sixfold difference in hysterectomy and prostatectomy rates among communities in New England.[4] And another study revealed twice as many carotid endarterectomies and half as many coronary bypass procedures per capita in Boston, compared with New Haven, CT.[5] (See Box on p. 36.)

Although in many cases these studies did not provide direct evidence for inappropriate, overused, or underused practices, they certainly documented the need for a careful examination of the appropriateness and the quality of the outcomes.

Participants in Guideline Development

The medical profession has led the way in developing practice parameters. The first guideline was published by the American Academy of Pediatrics in 1938. Currently, more than 1,300 guidelines are in the process of being published or are already in print. More than 50 physician organizations; public agencies; and private researchers, payers, providers, and other groups are involved in practice guideline development. In addition, allied health professionals and private payers are beginning to participate in the efforts of the Agency for Health Care Policy and Research (AHCPR).

In response to the economic and healthcare forces that generated private-sector guideline development, the federal government has also joined the fray. The AHCPR was created through the Omnibus Budget Reconciliation Act of 1989. This legislation mandated establishment of the AHCPR, through the Office of the Forum for Quality and Effectiveness in Health Care, to help develop clinical practice guidelines, standards of quality, performance measures, and medical review criteria.

AHCPR's Perspective

The AHCPR defines clinical practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."[6] This definition is based on the belief that clinically sound, evidence-based guidelines could improve quality of care. Additional research demonstrates that high-quality care, delivered efficiently, also reduces healthcare costs.[7]

The increasing complexity and rapid growth of medical science and technology have been major stimuli for the development of clinical practice guidelines.

The Institute of Medicine has cited five major purposes for guidelines[8]:

- Assisting patients' and practitioners' clinical decision making
- Educating individuals or groups
- Assessing and ensuring the quality of care
- Allocating healthcare resources
- Reducing the risk of legal liability for negligent care

The Process

The Office of the Forum for Quality and Effectiveness in Health Care is authorized to lead guideline panels by convening expert panels or contracting with private and not-for-profit groups. These two mechanisms have been used since 1990. The guideline is thus a product of a private-sector panel of experts, supported by the AHCPR.

The AHCPR guideline development process used by the expert or contract panels is a rigorous, evidence-based methodology. Analysis of relevant literature involves a variety of processes, ranging from consensus of experts (when the literature evidence is insufficient) to meta-analysis of explicit evidence. In addition, analysis of claims data and private-sector data bases helps to describe current practice and provides baseline information on each guideline's health policy impact.

Previously, most guidelines issued by specialty societies, federal agencies, and task forces have been consensus guidelines, developed by a convened group of experts.[9] Today, many professional organizations are using more rigorous guideline development methods involving extensive review of existing literature and analysis of data with conclusions on explicit evidence. Significant enhancements of guideline quality, credibility, and applicability are the goals of evidence-based guidelines, which link recommendations on the quality of the underlying evidence to outcomes.[10] The AHCPR guideline methodology is designed to produce evidence-based guidelines that are valid, clinically applicable, and clinically flexible.

The process begins when the AHCPR selects topics using several criteria. Guideline topics must relate to:

- Clinical conditions with high resource utilization
- A significant number of affected individuals

CLINICAL PRACTICE GUIDELINE TOPICS

- Management of Functional Impairment Due to Cataract in the Adult
- Diagnosis and Treatment of Benign Prostatic Hyperplasia
- Acute Pain Management: Operative or Medical Procedures and Trauma
- Management of Cancer-related Pain
- Diagnosis and Treatment of Depressed Outpatients in Primary Care Settings
- Sickle Cell Disease
- Prediction, Prevention, and Early Intervention of Pressure Ulcers
- Treatment of Pressure Ulcers in Adults
- Urinary Incontinence in Adults
- Initial Evaluation and Early Treatment of the HIV Infected Individual
- Low Back Problems
- Development of Quality Determinants of Mammography
- Otitis Media in Children
- Heart Failure: Outpatient Care of Symptomatic and Asymptomatic Patients with Left Ventricular Systolic Dysfunction
- Post Stroke Rehabilitation
- Screening for Alzheimer's and Related Dementias
- Cardiac Rehabilitation
- Chest Pain Due to Unstable Angina

• Significant variations in practice patterns for the condition

Selected topics are those believed to have enough available data on outcomes for evidence-based guidelines to be developed. Currently, 18 guidelines are under development or revision (see Box, above).

Expert panels for each topic complete the guideline development. AHCPR seeks nominations for panel members through *Federal Register* announcements and through direct mailings to private and professional organizations or individuals. Panels, which average 15 members, are multidisciplinary and always include consumer representatives.

Each expert panel spends a year or more developing the clinical practice guidelines. They begin with an extensive literature search and review of 5,000 to 100,000 relevant articles. The panel prepares evidence tables (summaries of all relevant data, risks, and harms), statistically analyzes aggregate data (where appropriate), conducts harm and benefit analyses, and prepares health policy analyses before it develops the evidence-based recommendations that become the clinical practice guideline.

Many professional societies have recommended the guidelines as course content for residency programs and credentialing.

During the process, each panel holds an open forum to solicit comments on the guideline topic. Each open forum is announced in the *Federal Register*, and the AHCPR sends announcements to hundreds of professional organizations, industry, insider groups, consumer groups, academic centers, and other groups and persons.

After this public discussion, the panel prepares a final draft of the guideline. This draft is circulated widely to clinicians, researchers, and consumers. Several hundred individuals may review the guideline at this stage. In addition, clinicians are asked to test the guideline with patients in their practice. After this peer and pilot review, revisions are made and occasionally sent for additional peer review before the final version is submitted to the AHCPR. The guideline is then updated to incorporate new literature evidence, new products, and experience or feedback from the guidelines' utilization.

Products and Perspectives

The clinical practice guidelines are designed to be useful to researchers, providers, and consumers. This is why AHCPR includes the extensive literature review and data analyses in the "Guideline Report," which usually is several hundred pages. The "Clinical Practice Guideline" (the clinician's overview) usually runs about 100 pages. In addition, a shorter "Quick Reference Guide" is intended to be the guideline's practical form. An important part of each guideline is the "Consumer Guide," prepared in English and in Spanish, to assist consumers in making informed healthcare decisions.

Primary care providers are the guidelines' principal audience. To ensure the guidelines' broad dissemination, AHCPR has established a clearinghouse. (To order guideline products or to obtain further information on their availability, call the AHCPR clearinghouse toll-free at 800-358-9295, or write to AHCPR Publications Clearinghouse, PO Box 8547, Silver Spring, MD 20907.) The clearinghouse will soon Fax press releases that highlight each guideline's major findings.

Persons interested may soon be able to access guidelines (with full-text retrieval) from the National Library of Medicine, CD-ROM versions, and computerized documentation systems that prompt clinicians to document practice based on guideline recommendations. Also, AHCPR supports evaluation studies on computerized applications of guidelines for documentation, decision making, continuous quality

improvement, healthcare provider behavior change, and a determination of whether outcomes have changed as a result of guideline usage.

AHCPR has released three clinical practice guidelines to date: "Urinary Incontinence in Adults," "Prediction, Prevention, and Early Intervention of Pressure Ulcers," and "Acute Pain Management: Operative or Medical Procedures and Trauma."

The urinary incontinence panel concluded that most patients with urinary incontinence, which affects approximately 10 million Americans at an estimated annual cost of $10 billion (based on 1987 dollars), can be successfully treated. The guideline addresses appropriate diagnosis for this underdiagnosed and underreported condition. It also includes recommendations for treatment, including behavioral, pharmacological, and surgical approaches.

The pressure ulcer guideline panel concluded that most pressure ulcers can be prevented and recommended steps to attain that goal.

The pain management panel's literature search clearly revealed that pain is significantly undertreated. The guideline recommends tools for pain assessment and pharmacological and nonpharmacological methods of pain control. It also discusses pain control for specific operative sites and for specific types of management and includes a formal, institutional approach to management of acute pain.

Guideline Application

Some policymakers believe clinical practice guidelines can lead to better healthcare outcomes. Evidence that these goals can be realized includes the basic intraoperative monitoring practice parameters of the American Society of Anesthesiologists, which reduced patients' injuries from oxygen deficiencies and reduced liability premiums of the professionals who used the parameters.[11] After the introduction of American College of Cardiology practice parameters on appropriate use of pacemakers in 1983, the use of pacemakers declined 25 percent during the following year.[12] Over a four-year period the total Medicare savings from this decrease amounted to $750 million dollars.[13] Numerous other examples of practice parameters' positive impact on quality and cost exist.[14]

The AHCPR has authorized a work group to establish a methodology for developing medical review criteria, standards of quality, and performance measures from clinical practice guidelines (see Box, p. 34).

During the guideline development process, each panel holds an open forum to solicit comments from professional organizations, insider groups, and others on the guideline topic.

Guideline Implications

The guidelines have many implications for practice, education, administration, and research. Their major benefit is they provide information in a useful format for clinicians to use at the bedside or the point of decision making in patient care. The AHCPR and professional associations are disseminating guidelines to as many individuals as possible. To date, more than 1.5 million guidelines have been released in the first six months of their availability. Feedback from clinicians and consumers will help the panels update the guidelines.

Guidelines provide information that can be used in continuing education and professional education programs. Professional organizations have endorsed the guidelines. Many professional societies have also recommended the guidelines as course content for residency programs and credentialing.

States and hospitals have used the first three guidelines released to help formulate health policy. One state's governor's commission has implemented guideline recommendations to determine patient admission policies for nursing homes. Other states are demonstrating the usefulness of guidelines in protecting physicians from malpractice litigation.

Identification of research deficits has resulted from each expert panel's work and has made significant contributions to helping to define the direction and content of future research. Despite the extensive literature that exists in some (but not all) of the guideline topics, each of the panels has uncovered some basic science, applied science, health policy, and other issues that need further research. In addition to these questions, the expert panels have consistently identified research deficits in the areas of patient preference, patient satisfaction, compliance with treatment, costs, and access.

Positive Impact

The AHCPR guidelines use a rigorous process of development for products that are intended to improve the quality of healthcare delivery. These clinical practice guidelines differ from previous initiatives in that they are evidence based and involve multidisciplinary groups. Other differences are that the AHCPR guidelines feature a health policy impact study, engage the private

sector in the open forum and peer review processes, and are written for both healthcare providers and consumers.

The AHCPR believes that clinical practice guidelines will have a positive impact on the quality and effectiveness of healthcare in this country through information analyzed, synthesized, and provided to practitioners, patients, and researchers. New guidelines are expected to be released by the end of 1992 and throughout 1993. □

Some policymakers believe clinical practice guidelines can lead to better healthcare outcomes.

NOTES

1. Roger I. Lee, quoted in Marilyn Field and Kathleen Lohr, editors, *Guidelines for Clinical Practice: From Development to Use*, Institute of Medicine, National Academy Press, Washington, DC, 1992.
2. D. T. Durack, "The Weight of Medical Knowledge," *New England Journal of Medicine*, vol. 298, 1978, pp. 773-775.
3. John E. Wennberg and A. Gittlesohn, "Small-area Variation in Health Care Delivery," *Science*, vol. 182, 1973, pp. 1102-1108.
4. John E. Wennberg, Physician Payment Review Commission, 1989.
5. John E. Wennberg et al., "Are Hospital Services Rationed in New Haven or Over-utilized in Boston?" *Lancet*, vol. 1, 1987, pp. 1185-1189.
6. Field and Lohr.
7. E. C. Pierce, "The Development of Anesthesia Guidelines and Standards," *QRB*, vol. 16, 1990, pp. 65-70; J. T. Kelly and J. E. Swartout, "Development of Practice Parameters by Physician Organizations," *QRB*, vol. 16, 1990, pp. 54-57; Testimony of the American Society of Internal Medicine to the Ways and Means Committee on Practice Guidelines and the Volume of Services, May 3, 1990.
8. Field and Lohr.
9. Stephen H. Woolf, "Practice Guidelines, A New Reality in Medicine II: Methods of Developing Guidelines," *Archives of Internal Medicine*, vol. 152, 1992, pp. 946-952.
10. Woolf.
11. Pierce.
12. Kelly.
13. Testimony of the American Society of Internal Medicine.
14. Testimony of the American Society of Internal Medicine.

METHODS FOR TRANSLATING GUIDELINES

To develop methods for translating clinical practice guidelines into medical review criteria, standards of quality, and performance measures, a work group has been organized by the Office of the Forum for Quality and Effectiveness in Health Care, which is part of the three-year-old Agency for Health Care Policy and Research.

The work group, which first met last March, is producing a document that will briefly describe the development of clinical practice guidelines and the methods for deriving medical review criteria, standards of quality, and performance measures.

Addressing the Issues

The manual will also discuss the issues associated with developing and implementing criteria, standards, and measures. These include who should develop the criteria, standards, and measures; how to choose which criteria to develop; and interpretation and measurement.

Implementation issues include the education and training of those who develop and use the criteria, standards, and measures and how to build the criteria into care and quality improvement systems.

Considerations related to legal issues and legislation will also be discussed, according to David Sundwall, MD, vice president and medical director of AmHS Institute, Washington, DC, who cochairs the work group with Stephen Schoenbaum, MD, deputy medical director, Harvard Community Health Plan, Brookline, MA.

A Multidisciplinary Approach

The work group's 18 members, representing the disciplines of medicine, nursing, health information management, health services research, health policy, and law, come from a broad spectrum of organizations—hospitals, managed care organizations, insurance, and long-term care—as well as from academic medicine and nursing. Federal liaisons from the Department of Defense, Veterans Administration, and the Health Care Financing Administration also consult with the work group.

A Useful Tool

The group plans to complete its document in 1993. According to Sundwall, the manual is meant to be a source of information and assistance on the issues it raises for consideration. It will be available to a variety of organizations engaged in developing guidelines, evaluating healthcare, or improving the quality of care.

While the guidance in the document is intended primarily as a tool for the panels convened by or contracting with the Agency for Health Care Policy and Research to develop clinical practice guidelines, it is anticipated that many individuals and organizations will find it useful in their quality improvement, utilization review, and education activities.

—*Judy Cassidy*

Presentation by: EDWARD H. MILLS, M.D.
OWCP District Medical Director
Seattle, Washington

"Industrial Injury Management from a Physician's Perspective"

Society has placed the treating physician in an awkward position, if not a position of conflict of interest in many industrial injury cases.

The typical physician goes to medical school because he or she wants to treat sick patients and make them well. All of the physician's training is toward that goal and much knowledge is gained in that regard. Probably, the physician then goes on to specialize, and learns a great deal more about a smaller field, focusing attention on that area. If the physician is a surgeon, he or she tends to think about ways to help the patient by doing surgery, which they are trained to do, and like to do.

Basically, the physician doesn't treat the industrial injury patient any different than anyone else. The physician knows how to treat the injury or disease, but is not well equipped to handle the other requirements for the administration of the industrial injury. The physician generally is not knowledgeable, or interested, in causality. Most doctors will readily tell you they are their patients' advocates and believe that to be their job. They take the history, as related to them by the patient, as factual, and think no more about it. They may consider a statement of accepted fact as hearsay, and ignore it. If the patient tells them the trouble started at work and believes work caused the problem, the doctor will not question it. The physician knows the patient has access to the medical records, and to dispute the patient's opinion may interfere with the relationship. It may make an enemy in the community who will tell others bad things about the physician, or it may precipitate a law suit, especially if the physician operated on that patient, and the result was not as good as hoped for. Any malpractice insurance carrier will tell a physician that the best way to minimize law suits is to maintain good relationships with your patients.

The physician really doesn't care how a condition got there, if a patient has a carpal tunnel syndrome, for instance, the physician wants to operate on it and fix it. Somebody has to pay for it. The patient can't afford it or can't afford the time off without compensation. The employer has lots of money so let the company pay for it. If the claims people want to question the causality, they may, but the physician has not made the patient mad. The trouble is, this polarizes the physician so that if questioned later, he or she must defend their original position, or appear incompetent or dishonest. Further questioning may even be interpreted as harassment or unnecessary delay.

Another problem is that private insurance frequently won't cover treatment unless industrial insurance has denied responsibility. Even if the doctor is willing to go ahead with treatment, hospitals may not allow admission without payment guarantees. Regarding reporting and progress reports, the physician considers this a necessary evil which takes time, or office staff time. Either way it costs money.

In the role as patient advocate, the doctor is influenced by the patient regarding return to work and/or work restrictions. The doctor generally is not knowledgeable about jobs, and if the patient says he or she is still having too much pain to go back to work, that the employer only has very heavy work available, or that the company will take them back temporarily just so they can fire them, the doctor will assume the patient's statements to be true, and accommodate a request not to be released for work. To do otherwise, in essence, is calling the patient a liar. This is an area where conference calls, and the nurse intervention program can be of particular help by providing accurate information on the patient's job requirements, and by ensuring the employer's cooperation.

As we know from various studies, one done by the Dept of Labor and Industry in the state of Washington, the majority of patients who are injured get well, go back to work, and are no particular problem. It is the remaining 10 to 20% which account for 80% of the cost. This group frequently has had relatively minor trauma (strains & sprains) and may have little in the way of findings. When the problem patient ends up in the hands of the problem physician, not an infrequent occurrence, the costs rise geometrically. I believe the ratio for problem physicians may be similar to the ratio found for problem patients - ten to twenty percent.

On another issue, physicians' training does not prepare them for physical impairment rating. Rating requirements for compensation purposes are learned through on-the-job-training. Most states have their own rating systems and doctors frequently confuse state requirements with our own. Using the AMA Guidelines is good since it provides some guidance and uniformity. Most doctors, however, tend to find this work unpleasant, especially being called into court. This frequently happens in state cases and, even though it is extremely rare with OWCP cases, doctors usually don't differentiate between the two. Since one makes few friends in this activity, many physicians who have busy practices will not participate, or may not see any compensation cases at all.

Although the treatment for a given diagnosis is the same whether the condition is, or is not work related, there may be additional factors present in the work related condition. The diagnoses may be more difficult and the response to treatment may be affected. In the prospective study on disabling back pain done at Boeing by Doctors Bigos et. al., the most consistent predictor of back

trouble was a poor evaluation by one's foreman. This had greater correlation than any physical or x-ray findings, or the physical requirements of the job. Other studies have shown that depression is one of the most common causes of musculo-skeletal pain complaints.

Physicians' ability or willingness to recognize the contribution of non-organic etiology in pain complaints varies greatly. Accurate diagnosis and evaluation requires a careful, detailed history of symptoms and complaints. Not only is it necessary to determine where pain complaints are located, but their nature, degree, duration, and degree of restriction must be ascertained. Are the complaints disproportional to the findings? Are the complaints migratory? Is the degree of incapacitation beyond what one could reasonably expect for the diagnosis or findings? On physical exam one must look for non-organic findings or inconsistencies. Some of these have been described by Dr. Waddel, and he demonstrated their value in predicting the failure of back surgery to resolve a problem when evidence showed several of these findings to be present.

Motivation on the physician's part may play a role. It takes time to talk to the patient and understand his or her symptoms and problems. Sometimes attorneys accuse a physician who is checking for inconsistencies, of trying to trap the patient. This is not the case. It is necessary in making an accurate diagnosis so that medical treatment, if indicated, will be appropriate and effective. A physician, however, in leu of a careful history and physical examination, may be prone to ordering more tests, which don't take his or her time, and bring in more income. This is the easy way out, but it doesn't replace the time spent with the patient.

The big problems come when complaints of non-organic etiology are treated with surgery or, in my experience just as devastating, when treated with prolonged ineffective care of any type. The patient's original problems become compounded. He or she may become further alienated at the workplace, problems frequently develop at home, the patient may adapt a new life style, loose confidence, develop increasing dependency, etc. It is not hard to find examples in our case files where this has happened, and the disastrous results that follow.

The statistics on costs over the last few years obtained by OWCP demonstrate dramatic increases in costs despite evidence that there has been no significant increase and in some instances, a decrease in documentable traumatic injuries such as fractures, lacerations, etc. Historical observations may give some insight into etiology. In the early 1930's Dr. Simon Flexner performed a study, funded by the federal government, regarding the effectiveness of medical care in the U.S. The conclusion reached was that at that time, the chances of being helped by seeing a doctor and the chances of being hurt were equal, fifty-fifty.

In the thirty's there were an abundance of private medical schools (diploma mills without university affiliation). As a result of this study, stringent accreditation standards for medical schools were developed; many schools were closed, and those remaining, affiliated with universities. Scientific principles were applied to medical education and as a result, care was markedly improved.

Costs at that time were borne by direct billing to patients. Up through the 1950's all fees were generally paid directly by the patient. Usually the family doctor was the primary care physician, and patients were referred to specialists as necessary. There was, therefore, a built in screening process. Fees were somewhat dependent on ability to pay. A significant percent of billings were never collected. Most doctors spent at least 1 day a week taking care of indigent patients. In the 1960's major changes came. Medicare was instituted. Employer-paid medical benefits became common along with entitlement programs. The third-party carrier paid the bills. The patient lost interest in the amount. The carrier just raised rates, and usually collected a percentage of gross amount paid, so neither were the carriers necessarily interested in controlling costs.

Along with these changes, another major change occurred. There was great pressure to increase the number of doctors and specialists based on the mistaken concept that the economic principle of supply and demand would reduce costs. The problem is, demand is infinite as long as there is sickness, ageing, and death. Instead of reducing costs, infinite demand raises costs to the level of money available to spend.

It then became obvious that there were too many specialists being trained. Some studies were done that bore this out, but no one cut back. What professor wants to have a smaller department, and less residents in training to help him or her take care of patients, and write research papers?

At the recent Orthopedic Academy meeting, Dr. John Wennberg, Professor of Public Health at Dartmouth, reported that there appears to be a large excess of specialists: 3 times the number of pathologists, 2.5 times the number of neurosurgeons, and 1.5 times the number of orthopedists considered appropriate by HMO planners. He also pointed out that if a fifty percent cut in the number of urologists currently being trained were made today, there would be no reduction in the current number of urologists per given population in future years. If a 100% cut were made, it would take 20 years before a reduction occurred.

With this surplus of physicians, presumably in an effort to obtain "market share", has come a change in ethical standards. In addition to the "promotional" type scientific reports at medical meetings, news media reports, and interviews are now common. Even direct advertizing in yellow pages, newspapers, and radio occurs.

Some physicians "self refer" to therapy units in which they have a financial interest. Manufacturers of medical instruments and devices promote their products with minimal attention to scientific fact, and pay royalties to physicians who in turn promote the product.

Dr. Wennberg, along with others, have recently developed and promoted "Outcome Studies" which have yielded most interesting information. These studies differ from much customary medical research, in that they are broader in scope, well designed, and independent. Researchers evaluating injury and illness outcome have studied large population groups in different geographic areas and found that the treatment one receives is greatly influenced by where one lives. For instance, the incidence of open heart surgery in one major city was found to be twice that of another, in comparable population samples. There was no evidence of additional health benefits in the group with more operations.

Dr. Entohven, economist, pointed out at the Orthopedic Academy meeting, that in one area, the hospital with the lowest mortality in heart surgery had the lowest cost by fifty percent

Another interesting finding is that back surgery is done twice as commonly on the West coast as it is on the East coast, and five times as commonly as it is done in England.

The sad part of all this is that the public is led to believe that medicine has the answer to all their problems. They are now more willing to undergo and seek out additional treatment, and even actually bring pressure on surgeons to operate. As more and more is done, with less and less indication, the risks of a less than expected outcome rise. When things aren't perfect, the disappointed patient may sue, and the costs go higher. There is no doubt in my mind that the current need to practice defensive medicine markedly increases health care costs.

I agree with Dr. John Wennberg's proposals that we should:

a. Avoid the blind acceptance that more is better,

b. Avoid privatization of outcomes research,

c. Use 0.5% of our medical budget for outcomes studies.

Solutions to our current health care problems are not easy. One promising avenue includes development of practice guidelines and outcome studies. The availability of information which can affect the motivation of physicians and patients is essential. Many other mandatory controls on costs and delivery systems are currently being debated and will probably be necessary.

Presentation by: CHARITY I. BENZ
OWCP Regional Director
Boston, Massachusetts

EARLY CLAIM MANAGEMENT

Nurse Intervention as a Cost Containment Strategy

The Nurse Intervention Model

The basic premise of the Nurse Intervention Program is that registered nurses, acting on behalf of the U.S. Department of Labor, can assist injured workers to experience a safe return to work at the earliest possible time by:

1) Monitoring the treatment plan established by the attending physician

2) Assuring that the claimant receives appropriate and high quality medical care

3) Working with the employing agency and the claimant to coordinate a return to work that is suitable for the claimant's restrictions

The Process

The Boston District Office cases originally selected for a pilot in 1988 were back strains for which there were no apparent medical explanations for continuing disability. As the success of the program became apparent, selection criteria was extended to include every case in which disability extends beyond the 45-day continuation of pay period; the only hindrance is the availability of nurses, particularly in certain remote areas.

The process evolved over time. Initially, when the office was without staff nurses to assist in the referral process, in-house rehabilitation staff selected cases referred from examiners for the program, interviewed claimants, assigned nurses, and managed the cases from a rehabilitation perspective. Over time, staff nurses have been introduced into district offices to recruit and supervise a growing corps of field nurses, and to work with claims examiners to determine the appropriate medical strategies for individual cases. Now, in the Boston District Office, as many cases as possible are referred for nurse assistance, as early as possible in the disability period, and in some instances while the claimant is receiving continuation of pay.

Nurses visit with claimants and perform the following services:

1) Review the condition being treated, and the results of the diagnostic procedures performed, check to assure

that a treatment plan is in place, check drug and therapy regimens, and help with the scheduling of tests.

2) Work with the claimants to assure that they fully understand the nature of their condition, that they take responsibility for their recovery, and that they have a realistic expectation of the course the recovery should take.

3) Communicate and work with the attending physician to ascertain when the claimant's conditions can be expected to stabilize and what type of limitations will be imposed on the claimant's return to work.

4) Begin discussion with the employing agency regarding the nature and availability of light duty as soon as it appears appropriate to do so.

5) Facilitate the processing of documents by OWCP, including bills and claims.

6) Answer the claimant's questions and provide encouragement, reassurance, and support.

7) When the claimant is ready, return to work with him or her on their first day back and remain in touch with the claimant during the first sixty days of re-employment.

8) Monitor the return to duty with the employing agency to assure that the claimant's work restrictions are not exceeded.

9) Remain accessible to the claimant even after the case is closed.

The Results

The Boston District Office has used a varying number of nurses over the past five years, but until mid-1992 there were no more than ten at any one time.

Records show that 37.5% of the claimants who were assigned a nurse went back to work (181 of 483 cases). Those who did not return to work during the period when they were assigned a nurse, were either transferred to our rehabilitation program, or temporarily suspended form the nurse intervention program due to the protracted nature or seriousness of their medical condition.

In December of 1991, in the Boston District Office, there were 56 cases in the nurse intervention program with eight field nurses. In February of 1993, with the addition of a staff nurse, and a total of 27 field nurses, the program had 187 claimants with a

wide range of injuries and disabilities. New cases are being opened at a rate of approximately twenty to thirty per month.

Although a comparative study of the effectiveness of the Nurse Intervention Program in the Boston District Office has not been completed, there is anecdotal evidence that the program has facilitated claimants' return to work, and that the good will of the nurses has ameliorated claimants' anger, frustration and hostility.

The Agency Role

The employing agency's constructive and cooperative role in this program is essential to its success. While the nurse attempts to keep the employee focused on returning to work, it is critical that the employing agency's staff understand the wisdom and importance of assuring the employee a safe return to duty. FECA nurses, claims staff and management consistently reinforce this requirement with agency supervisors, injury compensation specialists, and facility managers. There simply is no tolerance in this program for hypocrisy because its success depends upon the nurse's credibility, and the trust placed in her or him by the parties in the case. In the absence of trust and acts of good faith, the successful outcome of the case is jeopardized and neither the claimant nor the agency are well-served.

It is important that supervisors and agency staff respond appropriately to an employee's injury and stay in contact with the injured worker during the recuperative period. Occasional calls or greeting cards reinforce the agency's commitment to the employee, keep the employee feeling valued and engaged in the agency's activities and help prevent cynicism and anger from poisoning the employee's attitude about the eventual return to work. This is nothing more than the application of common sense to the elements of human nature. it is an inexpensive investment in the future outcome of what could otherwise become a costly workers' compensation case.

Technology

Finally, the prompt transmittal of important information on case development is critical. The use of telefax, voice mail, and electronic mail among key parties in the case, including the claims examiner, field nurse, employing agency, physician, and the claimant representatives, greatly speed decision-making, approval of certain aspects of treatment plans, resolution of problems, preparation of job offers which meet the needs of the agency on the one hand and the restrictions of the attending physician on the other, the submission of job offers, and generally increase the discourse usually associated with dynamic case management.

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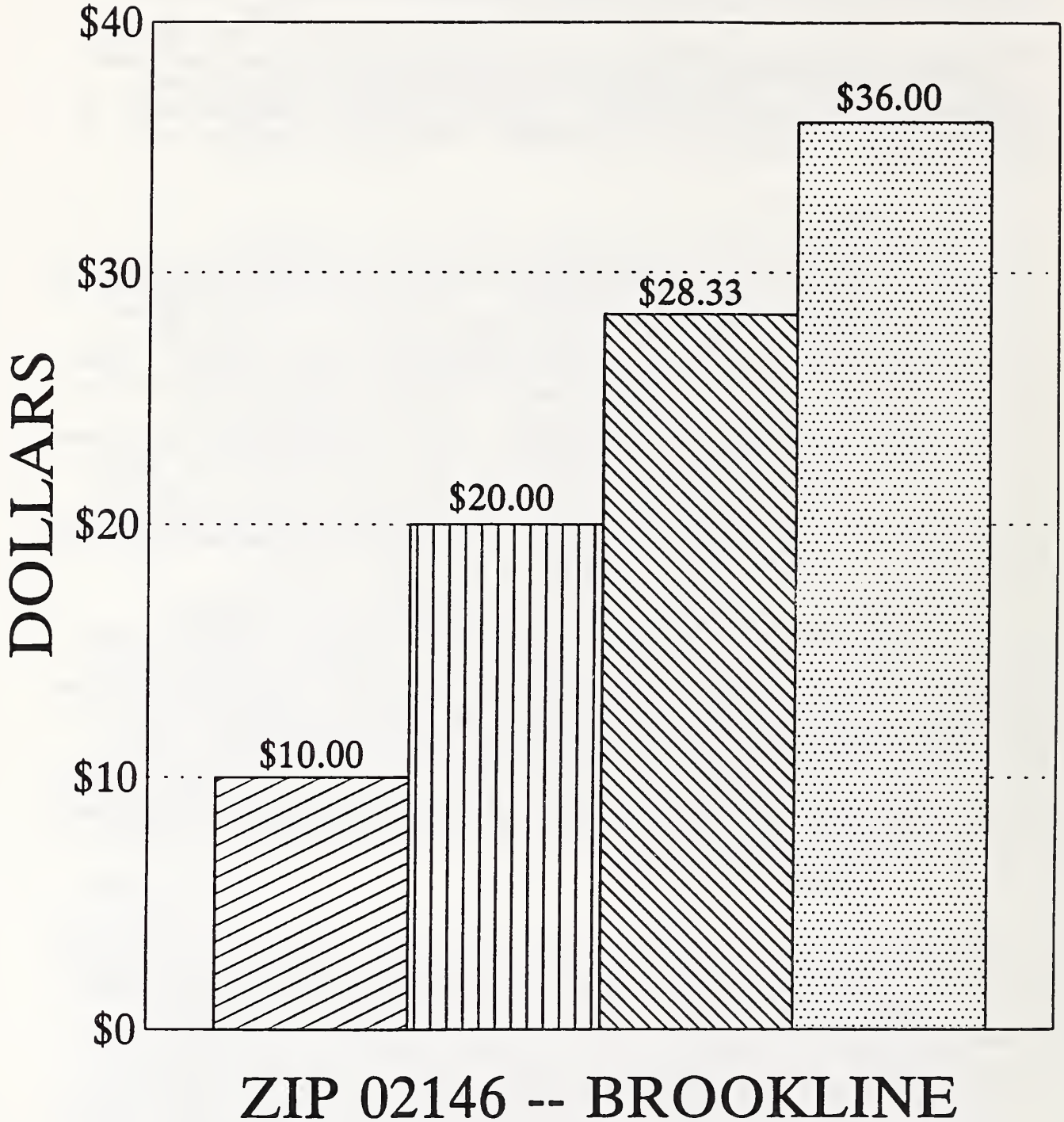
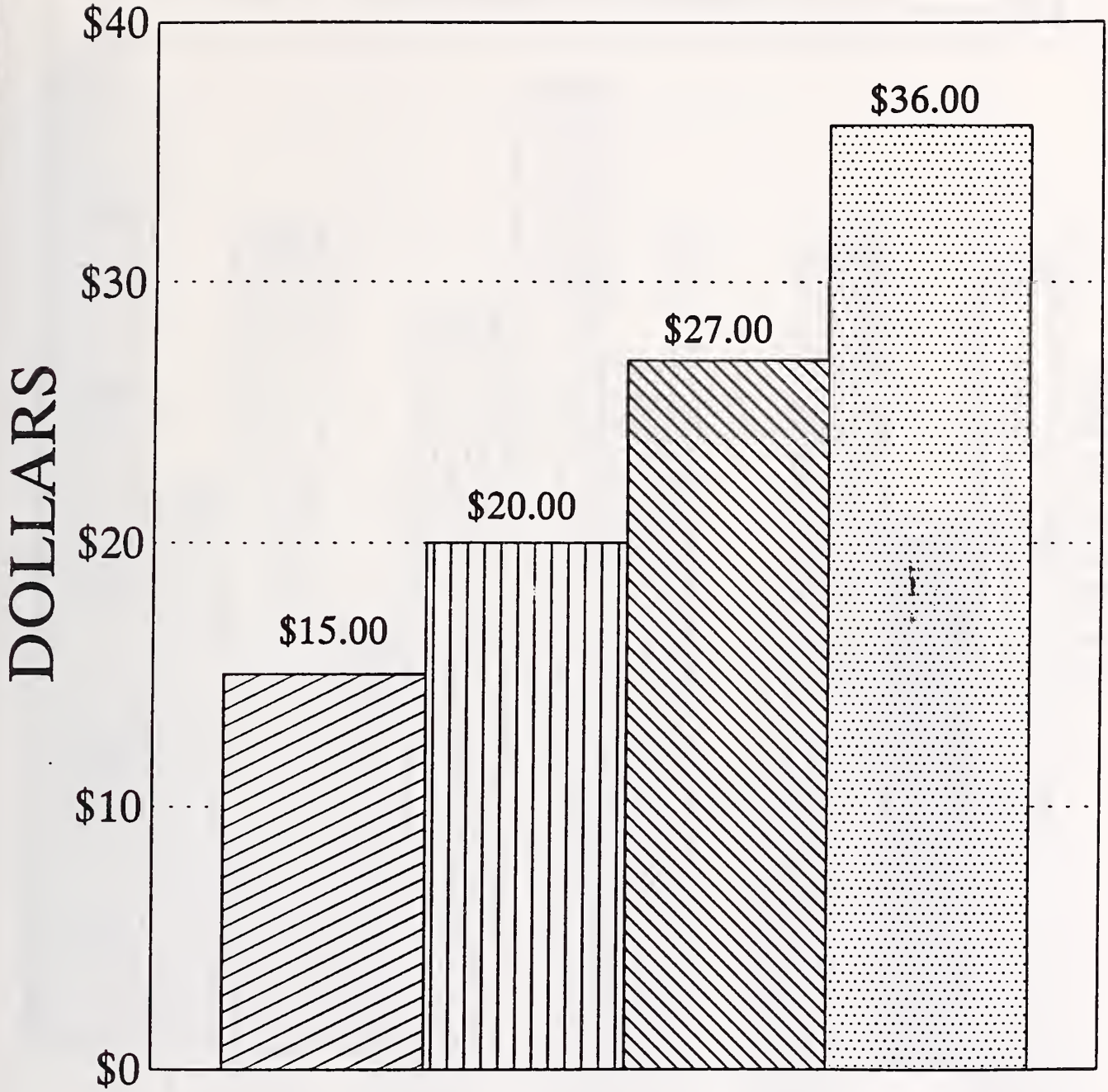


HOT/COLD PACKS (CPT:97010)



ZIP 02169 -- QUINCY

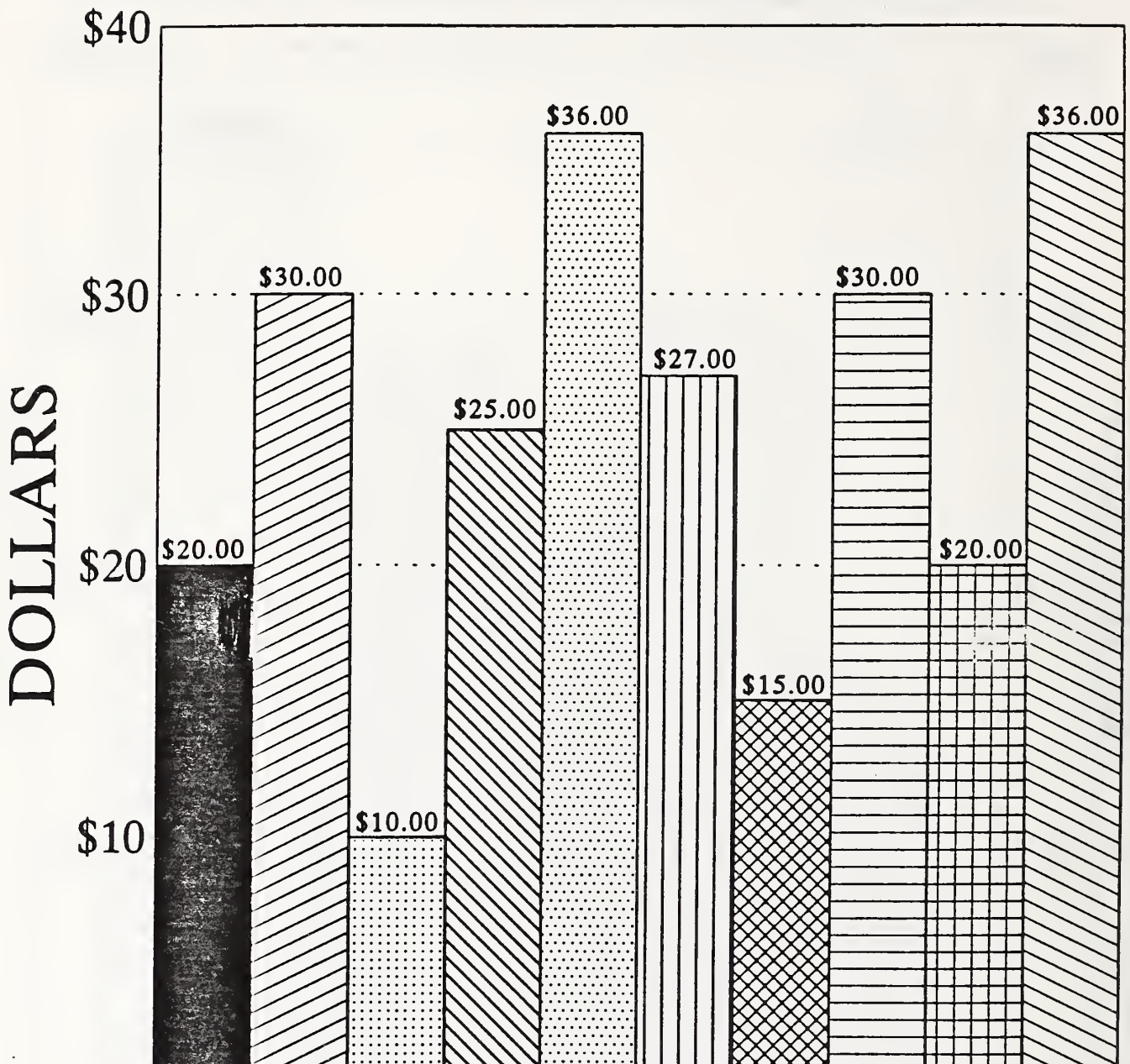
TAX ID #9

TAX ID #10

TAX ID #11

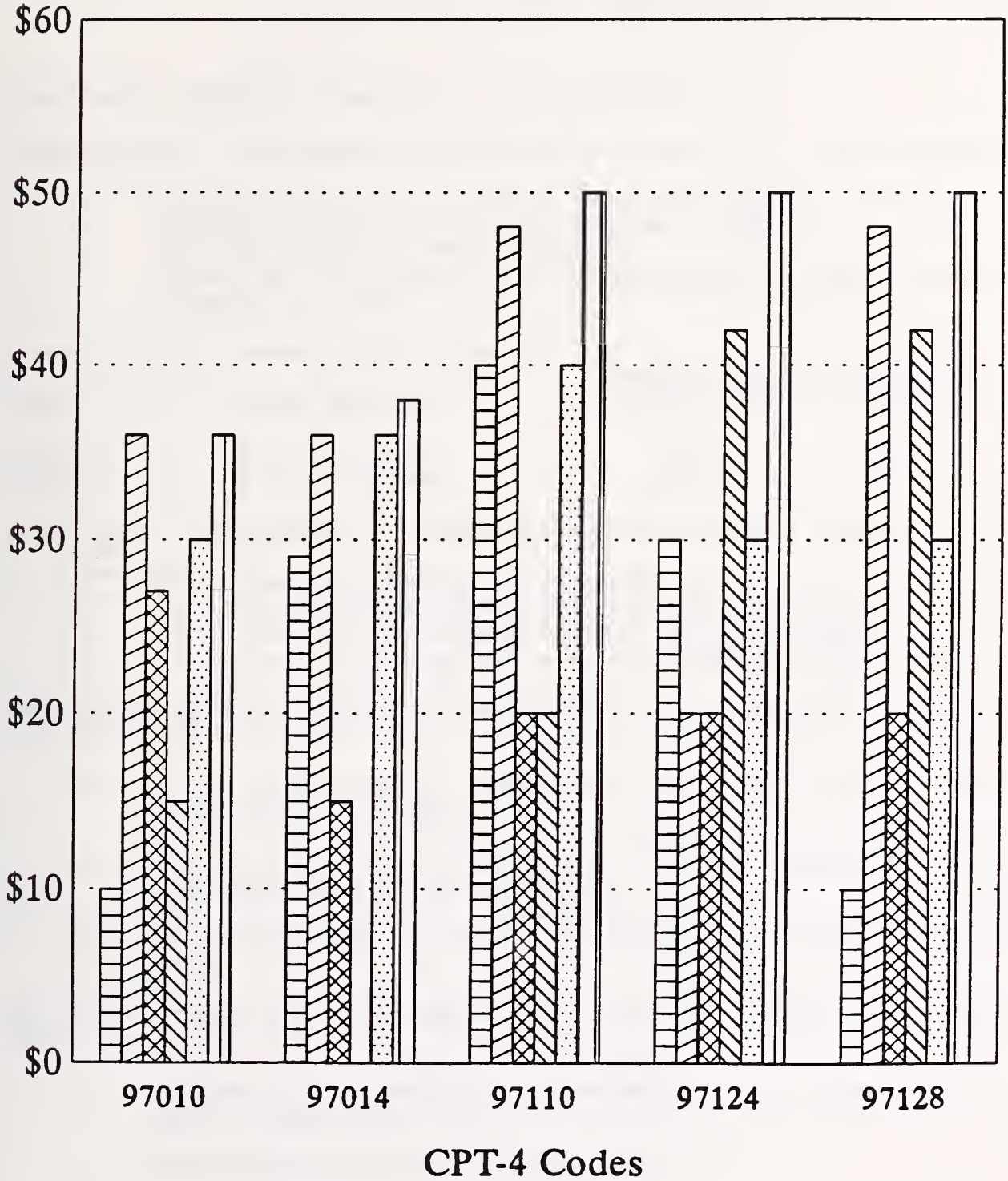
FEE SCHEDULE

HOT/COLD PACKS (CPT:97010)



02116 - Boston
02131 - Roslindale
02146 - Brookline
02148 - Malden
02154 - Waltham
02169 - Quincy
02176 - Melrose
02181 - Wellesley
12190 - S. Weymouth
FEE SCHED

THERAPY COSTS BY PROCEDURE CODE
Boston, MA Area Zip Codes -- 1/1/92 - 12/31/92



Presentation by: Glenn Whittington
Chief, Branch of Planning
Policy and Review, OWCP National Office

THE STATES EFFORTS AT MEDICAL COST CONTAINMENT

State workers' compensation programs are under a lot of pressure:

- Programs receive a lot of attention from the press
- Players are politically active and vocal
- The atmosphere is very volatile
- Almost 200 amendments to state compensation programs were enacted in 1992

State workers' compensation benefits:

Year	Total Benefits	Percentage Distribution Indemnity	Medical
1979	$ 9.5 billion	71%	29%
1989	$32.8 billion	60%	40%

Traditional state workers' compensation cost control methods:

- 31 states have medical fee schedules
- 11 states use the "usual and customary" standard
- 5 states are developing medical fee schedules
- 4 states have no schedule or, if they do, don't use it

California Workers' Compensation Research Institute's findings on fee schedules:

- Limiting physicians' fees has little effect on the total cost of medical care
- There is increased billing for medical procedures not regulated by the fee schedule
- To control medical costs you must control utilization as well

Workers' Compensation Research Institute's findings on fee schedules:

- Unsure as to whether fee schedules are effective in controlling costs
- Other factors play an overall part

Traditional insurers' and employers' efforts at medical cost containment:

- Utilization review
- Case management
- Second opinion programs
- Independent medical examinations
- HMO's and PPO's

Non-traditional methods of cost containment:

- Self insure
  1980: 18.1% of employers self-insured
  1992: 29% of employers self-insured

  Greater control over workers' compensation costs, especially medical costs

  A major drawback to self-insurance has been the small size of some firms; this has been overcome by group self-insurance arrangements

- Ergonomics - grants to universities to study methods to reduce the risk of low back injuries and cumulative trauma have grown in number and grant amount

- Co-payments - under some arrangements to improve premium rate, the employer pays the first dollars (e.g. first $100 on a claim)

- Co-insurance - under some arrangements to improve overall premium rate when the policy covers both work and non-work related injuries, the employee contributes to the non-industrial injury premium portion

- In some instances, collectively bargained solutions are being substituted for statutory ones

- Combining medical care for both workplace and non-workplace injuries in one package - the "twenty-four hour coverage" concept; the following states have relevant legislation, but there are no active programs at this time:

Florida	1990
California	1992
Georgia	1992
Alabama	1992
Maine	1992
Oregon	Imminent

- Some states have mandated safety and health committees and/or programs:

  Minnesota
  Missouri
  South Dakota
  Tennessee
  Utah

Recommendations of the National Conference of State Legislatures' Task Force on workers' compensation:

- Workers' compensation cannot go its own way
- Escalation of health care costs drives workers' compensation medical costs higher
- Workers' compensation would benefit from greater use of some cost and quality controls common to the health care network

Presentation by: KEVIN HAUGH
Institute for Health Policy Solutions
Washington, D.C.

TWENTY-FOUR HOUR COVERAGE AND OTHER WORKERS' COMPENSATION MEDICAL COST ISSUES

We have already talked about the reasons for rapid escalation in workers' comp health costs. They include: proliferation of medical technology, cost shifting from other health plans (Medicare, Medicaid, and private payers), increased generosity in workers' compensation programs, and increased litigation. In addition to these factors, in recent years the number of uninsured Americans has grown by nearly 10 million (with Medicaid cutbacks, lower incidence of employer coverage etc.) To the extent uninsured individuals do tend to use workers' comp as a primary source of health coverage, this is another important factor behind growth in costs.

We have seen lots of data today on growth in workers' comp medical costs. Figure 1 provides a somewhat different picture of how workers' comp health cost growth in recent years compares with overall growth in health care costs and payments under private health insurance. As can be seen, workers' comp costs have grown at a much more rapid rate in recent years.

Workers' comp costs have also grown significantly as a percentage of employer payroll to roughly two and one-half percent of payroll today. However, these figures in many senses do a disservice to the underlying economic burden of workers' comp to many employers. In order to get a picture of this one has to look at distributional data for employers. For example, as can be seen in figure 3, workers' comp costs for butchers in California are over 25 percent of payroll versus less than 1 percent of payroll for bankers and insurers. to an employer a 10 to 15 percent increase in costs that already represent 25 percent of payroll translate into a much bigger hit and economic burden than a 10 to 15 percent increase on less than one percent of payroll.

Larry mentioned the 24-hour coverage concept. The general idea is that you break the linkage between work and non work related benefits.

As can be seen in figure 4, there are a number of different types of 24 hour coverage. Our focus today is on one of these types: 24 hour medical coverage. This form of 24 hour coverage implies that

multiple insurance lines are often some of the strongest supporters of 24 hour concepts.

One of the reasons 24 hour coverage is being discussed today is it fits fairly neatly into comprehensive health care reform proposals. The Garamendi health care reform proposal for California has been on of the most visible attempts to integrate workers comp medical into health care reform. Under this proposal all Californians would have health coverage. A series of health insurance purchasing cooperatives (HIPCs) would be established and act as the purchasers of health benefits for the population. All health plans offering coverage through a HIPC would have to offer a standardized set of health benefits. Health benefits would be provided through more vertically integrated managed health care plans.

Individuals would be covered for their medical care through their HIPC plan whether or not injuries or illnesses were work related or not.

In such a total reform context, 24 hour medical coverage is perhaps easiest to conceive of. ERISA will likely be addressed more broadly in comprehensive reform. major reform also generally envisions standardization of benefits and movement towards universality of coverage, which makes 24-hour coverage much easier from a policy as well as implementation standpoint.

Short of major reform, consolidating the medical components of federal employee benefits would perhaps be easier to do than in the market place more broadly. Health benefits are much more universal (although part time and temporary workers are often not covered). And the federal employee benefits program provides a good framework for standardizing benefits.

Can we expect cost savings from 24 hour coverage? It depends greatly on the form that 24 hour coverage takes. It appears that 24 hour coverage holds the potential to reduce system and workers' comp costs. However, there are both inflationary and deflationary factors that one could expect from movement to 24 hour coverage. Some of the *potential* deflationary factors include (1) closer management of medical care, (2) reduction in duplicate payments, (3) reduction in provider fraud, (4) standardized benefits and practices, (5) reduced legal and/or other administrative expenses. The fourth area is perhaps the least likely of all potential

coverage of medical care would be consolidated under a single health benefit plan.

While discussions about 24 hour medical coverage focus on the consolidation of workers compensation with traditional medical coverage, it is important to note that 24 hour medical care concepts generally go beyond this to also include health coverage provided through automobile insurance coverage.

A number of reasons are often cited for movement toward 24 hour coverage. These include (1) providing better management of medical costs than is currently the case under the workers' compensation and auto systems. Traditional cost management practices such as HMOs and PPOs have been slow to emerge in these markets. (2) Eliminate the ability to "cost shift" to workers' comp and auto plans. (3) providing better continuity of medical care (Presently people often a totally different set of medical providers whether injury is non- work, work, auto related). (4) Reduce administrative costs of running separate systems of medical coverage.

The key question of course is can 24 hour coverage meet these oft cited expectations. Related to this question is what types of barriers there are to the implementation of 24 hour medical coverage.

Some of the key barriers that are often mentioned include: (1) the Employee Retirement Income Security Act (ERISA)—federal law which raises questions as to whether coverage that is not provided *solely* for the purpose of covering workers' comp claims can be regulated by the states, (2) the very different benefit levels between the workers' compensation system and traditional health benefits (3) the prospect of endangering the exclusive remedy nature of the workers' comp system, (4) lack of universal coverage, (5) lack of experience in managing workers' comp claims.

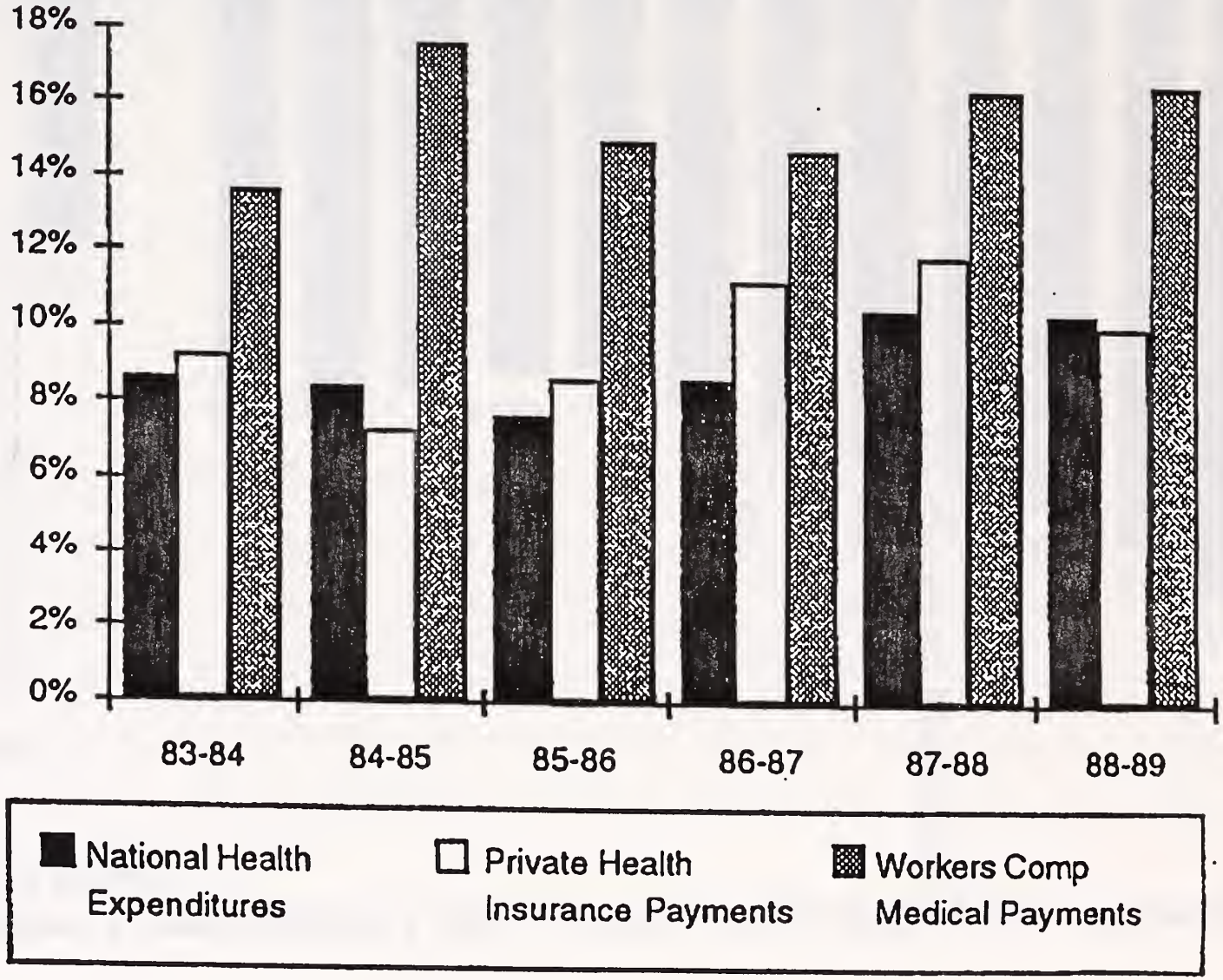
There are also important political issues and barriers. Health care providers and lawyers that have developed a livelihood in the workers' comp area will be threatened. Labor is concerned that movement to a 24 hour system could mean a reduction in total compensation. Finally, particularly single line, workers' comp insurers will likely oppose a system in which they are not well positioned to enter. On the other hand, companies that are in

deflationary factors since most such costs would remain so long as it was necessary to determine the location of injury or illness for wage replacement purposes.

On the inflationary side, consolidation could result in (1) cost shifts back to the health system, (2) establishment of a more comprehensive and costly consolidated benefit plan, (3) reductions in incentives for employers to establish a safe work environment, and (4) reductions in incentives to return employees to work.

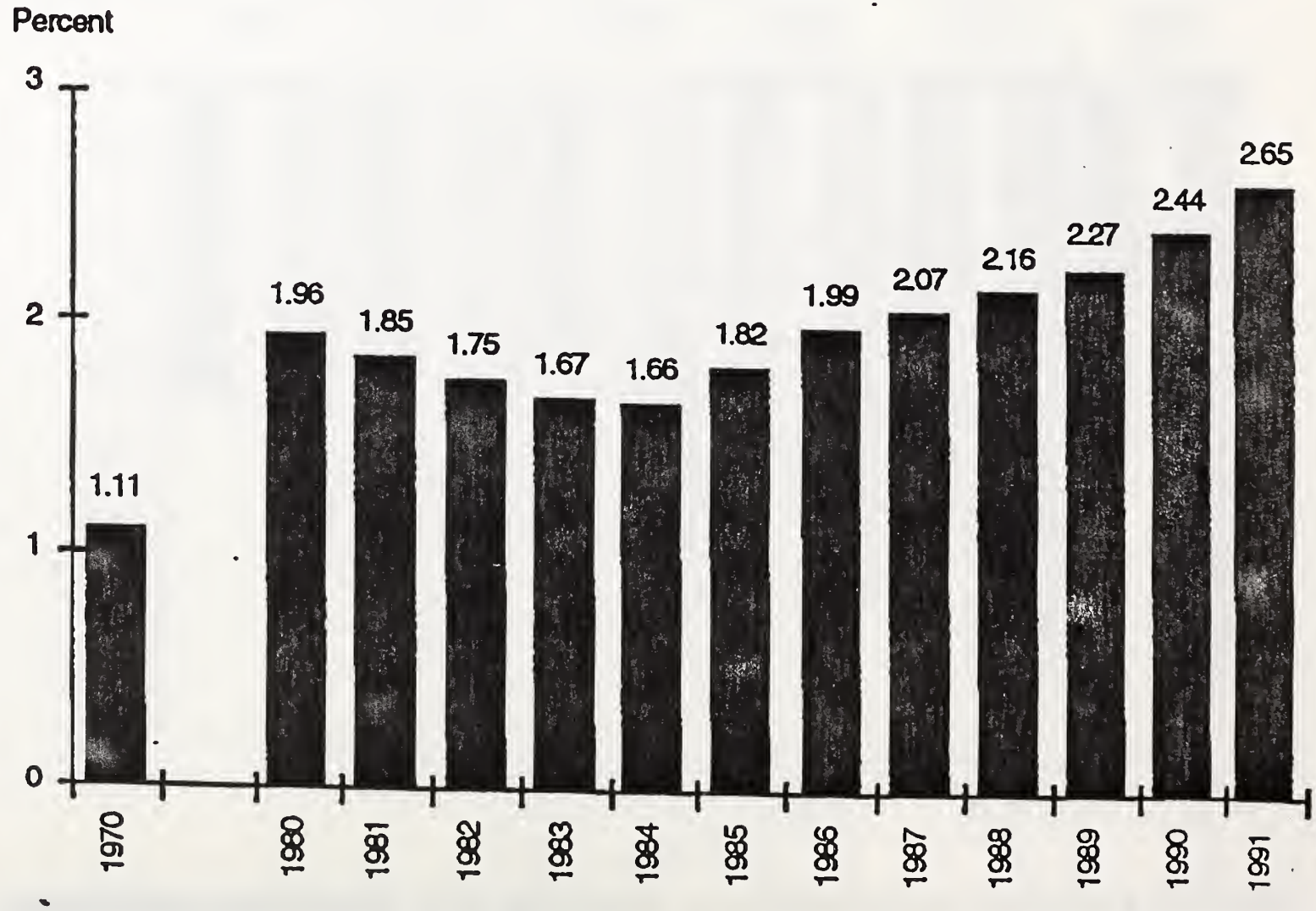
In summary, while the concept of 24 hour coverage has great appeal from a public policy standpoint, there are few places where the political capital involved in changing the system is as great relative to the immediate benefits. Workers comp costs represent around 3 percent of total health care costs. Auto medical represents another one and a half percent or so. While folding these systems in may be desirable, it will need to be done with great care to ensure that the outcomes are consistent with the goals of doing so. In addition, it behooves policymakers to look for possible win/win opportunities. The most important constituencies that need to perceive a gain from the system are labor and employers. The Garamendi plan architects have attempted to provide a win/win by using some of the anticipated savings from 24 hour coverage to increase wage replacement benefits. There are other ways to ensure that labor perceives a positive gain from system change.

Percent Growth in National Health Expenditures, Private Health Insurance Payments, and Workers' Compensation Medical Payments



Sources: HCFA and Social Security Administration

Workers' Compensation Costs as a Percentage of Employer Payroll, United States



Source: Social Security Admin and John Burton

Workers Compensation Costs for Selected Industries In California, As a Percent of Payroll, 1992

Banks	**1.34%**
Insurance	**1.46%**
Butchering	**25.10%**

Source: California Rate Manual

Some Different Types of 24 Hour Coverage

- 24 hour marketing
- 24 hour medical
- 24 hour disability
- 24 hour accident
- 24 hour medical and disability

Workers' Compensation and Auto Insurance Costs and Total Health Care Expenditures, United States and California, 1991

	Workers' Compensation		*Auto Insurance*		*Total Health Care Expenditures*	
	United States	*California*	*United States*	*California*	*United States*	*California*
Total Costs/Premiums[a]	$62	$10.9	$103[b]	$13.9	$740[c]	$107[d]
Total Benefits/Claims Paid[e]	43	7.3	70	8.8		
Medical	18	3.6	9.8	1.2-1.9[f]		
Other	25	3.7	60.2	7.6-6.9		

[a]"Premiums" are on an earned basis. In the case of non-insured business, costs are estimated premium equivalents or costs reported from government funds.

[b]Auto premiums are "direct earned premiums" and do not yet include indirect premiums (i.e., they are net of reinsurance).

[c]U.S. health care expenditures for 1991 are based on a Congressional Budget Office estimate provided in a report entitled "Selected Options for Expending Health Insurance Coverage," July 1991.

[d]California health care expenditures are derived by extrapolating from a Lewin/ICF estimate for 1990 provided in "Emergency: Rising Health Costs in America," Families USA Foundation, October 1990.

[e]These estimates are for benefits paid during the year, and are somewhat lower than benefits or losses incurred.

[f]We present a range to reflect two different estimates for medical claims as a percentage of total automobile claims payments in California.

Some Key Barriers Often Referenced

- Lack of universality
- ERISA
- Different providers and services
- Different benefits
- Lack of experience in managing workers' comp claims
- Continuity problems
- Individual interest in being made "whole"
- Different regulatory structures
- Remaining work/nonwork determinations

Some Political Issues

- Labor
- Trial lawers
- Specialty Providers
- Single line workers' comp companies

Key elements of managed competition
(a natural structure for 24 hour reform)

- Vertically integrated managed care plans
- Standardized benefits
- Less fragmentation
- Large, regionally based health care sponsors
- Universality
- Potential incorportion of nonemployed

Impact on Costs

Cost dampening effects

- Application of cost management
- Reduced fraud
- Administrative Coordination
- Standardized benefits
- Possible reduced administrative costs

Potential inflationary effects

- Reduction in experience rated premiums
  (not the same issue for federal employees)
- Cost shifts back to group health
  (not an issue for a segment of the market)
- introduction of a overly rich, consolidated benefit plan
- Introduction of other inflationary factors of workers' comp system into the consolidated system
  (e.g., litigation, overly cautious medial practices)

IHPS/KH

Some Options for "Win Wins" with Workers

- Increase in disability benefit
- Cafeteria plan
- Cost sharing "fill-in"/supplement

Presentation by: CHARLES R. BOOTH
Director, Office of Payment Policy
Bureau of Policy Development
Health Care Financing Administration, HHS

OVERVIEW OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS)

Introduction

Under the prospective payment system (PPS), Medicare (through its intermediaries) pays hospitals for their inpatient services at a predetermined rate for each discharge, according to the diagnosis-related group (DRG) assigned to each case. This prospectively-determined DRG rate covers operating costs and does not include payment to hospitals for capital-related costs, direct medical education costs, organ acquisition costs, or bad debts. Effective October 1, capital-related costs are also paid under a prospective payment system.

PPS applies to all Medicare-participating hospitals except psychiatric and rehabilitation hospitals and units, long-term care hospitals with an average stay over 25 days, childrens hospitals and cancer research hospitals. These hospitals continue to be paid their reasonable costs, subject to the target-rate-of-increase limits set forth in the Tax Equity and Fiscal Responsibility Act (TEFRA). There are special payment provisions for sole community hospitals, Medicare-dependent small rural hospitals, and rural referral centers.

PPS payments for inpatient operating costs are composed of six basic elements:

- the standardized prospective payments rates;
- the DRG relative weights to account for differences in the mix of patients across hospitals;
- a wage index to account for differences in hospitals' labor-related costs;
- additional payments for hospitals that serve a disproportionate share of low income patients;
- additional payments for the indirect costs of graduate medical education; and,
- additional payments for unusually expensive cases (outliers).

Prospective Payment Rates

The PPS standardized payment rates are the starting point in determining each hospital's prospective payment amount.

There are three steps behind the computation of the PPS payment rates:

- Standardization of base year (FY 1981) hospitals cost per discharge data to account for differences in case mix, wage rates, disproportionate share status and teaching activity (payment variables).

- Updating base year cost for inflation. (Update Factor)

- Grouping hospitals by urban or rural location in calculating average standardized costs. (Payment Rates)

First, each hospital's base year cost per case is standardized to control for the effects of differences in case mix, wages, disproportionate share status and teaching activity. Standardization is necessary because payment adjustments are made directly to each hospital for these payment variables.

The process of standardization involves deflating and/or inflating each cost per discharge value for these factors, so that the base year standardized cost per case indicates what each hospital's average cost per case would have been if the hospital incurred wage rates at the national average rate, had a case mix index of 1.0, no disproportionate share of low income patients, and no teaching program.

Second, the base year standardized cost per case were updated to Federal fiscal year 1984 (the first year of PPS) based on the national hospital market basket rate of inflation. The standardized payment amounts are update annually from one PPS year to the next by the PPS update factor which is set by Congress. In setting the update factor Congress considers both the Department's annual recommendations as well as those of the Prospective Payment Assessment Commission (ProPAC).

The final step in determining the payment rates involves grouping hospital by urban and rural location, and computing averages of the hospital standardized cost per case values.

Currently there are three standardized payment rates--a rural rate, a large urban rate (areas with over 1 million population), and an other urban rate. By FY 1995 the rural payment rate will be phased out, at which time hospitals will receive either the large urban rate or the other area rate. This will be accomplished through higher updates to the rural rate until FY 1995 when the rural and other urban rate will be equal.

DRG Relative Weights

Under PPS, the Federal prospective payment rate is adjusted for differences in the mix of cases treated among hospitals. This adjustment is made using a patient classification system called diagnosis-related groups (DRGs), which was developed at Yale University. Originally, patients were grouped into 470 mutually exclusive and comprehensive case categories. Each discharge is assigned to one of these DRGs based on principal and secondary diagnoses, procedures performed during the stay, as well as age, sex, and discharge status of the patient. The ICD-9-CM codes are used for reporting diagnosis and procedure information.

The actual payment a hospital receives for a patient is determined by multiplying the Federal payment rate by the appropriate DRG relative weight. The relative weights represent the relative level of resources used to treat the cases that are assigned to a given DRG. The weights are computed by determining the average standardized charge for the cases in a DRG divided by the average standardized charge for all cases and adjusting the result for aggregate changes in the Medicare case mix index..

The DRG classifications and relative weights are revised annually. Since implementation of PPS, DRGs have been deleted, added, and expanded to reflect changes in treatment patterns, technology, and other factors that affect the use of hospital resources. There are presently 489 DRGs. In addition, each year we use the latest available charge data as reported by hospitals to recalibrate the relative weights. Thus, as certain conditions and procedures become more or less expensive to treat compared to the average case, the relative weights of the DRGs to which they are assigned increase or decrease accordingly.

PPS Wage Index

Under PPS, the labor-related portion (about 71 percent) of the payment rate is adjusted for differences in PPS hospital wage costs between areas. This adjustment is made using the area wage index defined for about 367 urban and rural labor market areas. The wage index measures relative differences in the average hourly wage for the PPS hospitals in each labor market area compared to the national average hourly wage. For example, a hospital located in the San Francisco, CA Metropolitan Statistical Area (a high wage area) has a wage index value of 1.4517 compared to hospitals in rural Alabama (a low wage area) with a wage index value of 0.7127. The current wage index is based on data for cost reporting periods ending in calendar year 1988. Beginning in FY 1994, the wage index will be updated annually.

Computation of a Hospital's PPS Payment

The actual payment a hospital receives for a given discharge is determined by multiplying the wage-adjusted payment rate by the DRG weight appropriate to that discharge. Following is an example of how payment would be determined for a patient with chest pain who was hospitalized in San Francisco, California.

Large Urban Rate: Labor-Related Portion - $2,526.80
Nonlabor-Related Portion - $1,041.01

Wage Index for San Francisco: 1.4517

Relative Weight for DRG 143, Chest Pain: .5118

Wage-Adjusted Rate = ($2,526.80)(1.4517) + $1,041.01
= $4,709.17
Payment for DRG = ($4709.17)(.5118)
= $2,410.15

Additional Payment Adjustments

1. Indirect Teaching Adjustment

In recognition of the tendency of teaching hospitals to incur higher costs (even after adjusting for wages and case mix differences and for location), each hospital with a graduate medical education program receives an additional payment for indirect medical education costs based on the hospital's ratio of interns and residents to beds. This additional payment is currently set at approximately 7.7 percent of the DRG-adjusted rate for every .1 increment in the hospitals interns and resident to bed ratio.

2. Disproportionate Share Adjustment

The disproportionate share adjustment is intended to compensate hospitals for the additional costs associated with serving a significant proportion of low income patients. Under PPS, disproportionate share is defined as the sum of (1) the percent of Medicare hospital patient days attributed to Medicare beneficiaries entitled to SSI, and (2) the percent of total hospital days attributed to Medicaid recipients. Separate qualifying criteria and payment formulas apply to large urban hospitals, small urban hospitals, large rural hospitals and other rural hospitals.

3. Outliers

PPS provides additional payment in recognition of atypical cases that either require exceptionally long inpatient stays or generate extraordinarily high costs when compared to the overall distribution of cases in the same DRG. Payment for these cases represent the marginal costs above an established threshold.

Currently, to qualify as a length of stay outlier, the patient's stay must exceed the geometric mean length of stay for the DRG by the lesser of 32 days or 3 standard deviations. For each day in excess of the outlier threshold, the additional outlier payment amount is equal to 60 percent of the average PPS per diem payment for the applicable DRG.

To qualify as a cost outlier, the hospital's billed charges for a given case, adjusted to cost, must exceed the greater of $44,000 or 2 times the adjusted payment rate for the DRG. The additional payment amount for cost outliers is equal to 75 percent of the difference between the hospital's adjusted costs for the discharge and the threshold for cost outlier status.

Other Payments for Inpatient Hospital Services

1. Graduate Medical Education Costs

Medicare pays for the direct costs of graduate medical education based on the hospital's historical per resident cost in a base year (FY 1984) that is updated for inflation. The direct costs include resident salaries, physician compensation for teaching and supervision of residents, and any classroom or other overhead costs. Payment in the current year is determined by the actual number of residents and Medicare's inpatient utilization in the current year.

2. Capital-Related Costs

Effective with cost reporting periods beginning on or after October 1, 1991, Medicare pays for capital-related costs on a perdetermined amount per discharge. During the 10-year transition, the hospital's payment will depend on part on its historical capital-related costs and the hospitals will be protected for its prior capital commitments. At the end of the transition period, payment will be based solely on the Federal rate. The payment adjustments are similar, but not identical to, the payment adjustments used under the operating PPS system.

3. Organ Acquisition Costs

Organ procurement costs are reimbursable on a reasonable cost basis.

CONFERENCE DISCUSSION GROUPS

FINDINGS, CONCLUSIONS, AND SUGGESTIONS

DISCUSSION GROUP NO. 1

Chairperson: Edward H. Mills, M.D.

Subject: Application of "Medical Care Standards to Services Under the FECA

DISCUSSION GROUP NO. 2

Chairperson: Charity I. Benz

Subject: Early Medical Management of Disability

DISCUSSION GROUP NO. 3

Chairperson: Virginia I. Miller, M.D.

Subject: Medical Cost Containment Initiatives

DISCUSSION GROUP NO. 4

Chairperson: Glenn Whittington

Subject: Twenty-four Hour Coverage of Medical Care

DISCUSSION GROUP CONCLUSIONS AND SUGGESTIONS

DISCUSSION GROUP NO. 1

APPLICATION OF "MEDICAL CARE STANDARDS" TO SERVICES UNDER FECA

Discussion Group No. 1 examined the applicability of medical care standards to injuries/illnesses covered under FECA, and relevant issues such as criteria that OWCP should use for the selection of standards. This discussion group came to the following conclusions:

A. Application of medical standards by OWCP could provide the means to:

1. Improve Patient Care

   - o Support appropriate medical care; reduce prolonged ineffective treatment
   - o Question care outside the standards
   - o Offer consultation when questionable care is being delivered
   - o Educate physicians on contents of standards
   - o Educate claimants on expected care and their responsibilities during the recovery process
   - o Standardize the medical management of claims
   - o Reduce unnecessary surgery
   - o Reduce overall costs via improved care; high quality care hastens recovery
   - o Provide a constant for research

2. Lessen subjectivity of the decision regarding authorization or denial of treatment/services/equipment in the prior-authorization process

3. Notify the treating physician and the injured employee prior to the delivery of medical care what nature of services are considered necessary, effective, and appropriate care under the guidelines

4. Not differentiate services for work-related and non-work-related injuries (services would be applicable to both on and off the job injuries)

5. Avoid legal problems with the medical management of claims and medical care reimbursements if treatment standards are used as a guide to evaluate appropriateness of care, and if the treating physician is given opportunity to justify treatment outside the standards.

B. Medical standards acceptable to OWCP must be medically sound and have the following characteristics:

1. Validity (does what it says it will do)

2. Reliability and reproducibility

3. Clarity and explicitness

4. Clinical applicability

5. Clinical flexibility (able to meet variable needs and allow for judgement)

6. Applicable to multidisciplinary circumstances

7. Well documented

7. Subject to scheduled review and update

C. For implementation by OWCP, a medical standard must:

1. Be applicable to a high cost/high frequency injury under FECA (apply to high risk conditions and/or high cost procedures), such as:

low back injuries
carpal tunnel/repetitive motion injuries
psychiatric and stress related illnesses

2. Accommodate variation in geographic practice

3. Address any variance from other available standards

4. Be substantially based on documented objective data

D. Successful implementation of medical standards by OWCP would require:

1. Education of providers, patients, and claims managers (explanation of the guides, interpretation, reimbursement rules, exceptions, justification for variance, etc.)

2. Logistics planning to include key issues such as:

- o means to make patient and treating physician aware of guides early on in the treatment plan

- o public notification and discussion groups with federal agencies, union representatives and providers

3. Further enhancement of OWCP's automated systems to track implementation and capture data to evaluate impact on outcome (patient recovery, return to work and costs)

E. Implementation of standards by OWCP must be accompanied by a plan to measure their impact on programs affected:

1. Data on providers must be collected, e.g.:

Practice profiling
Utilization review

2. Injury outcomes must be measured

Patient recovery data
Health care costs
Monitoring costs
Effect on return to work date
Effect on patients' perception of care

3. Baseline data must be collected prior to implementation

DISCUSSION GROUP NO. 1 SUGGESTIONS

1. Review standards proposed by the Agency for Health Care Policy and Research to determine suitability for OWCP

2. Develop a plan to implement standards

a. Design a phase-in process
b. Educate providers, patients and claims examiners
c. Allow for the control of unnecessary, inappropriate, or excessive services

3. Plan for the measurement and evaluation of outcome

a. Design an evaluation study
a. Collect baseline data
b. Collect data for outcome measures
c. Schedule reports on findings

4. Develop a schedule for updating and ongoing evaluation of standards

5. Develop a plan for an interagency support group between the OWCP and the AHCPR for exchange of information, policy development and related research activities. For example: Conduct a study that will identify and quantify nationwide variations in medical diagnoses and treatment patterns for the care of injuries/illnesses under FECA. This study could provide the baseline data for the evaluation of impact of guidelines on injury outcomes and costs.

DISCUSSION GROUP NO. 2

EARLY MEDICAL MANAGEMENT

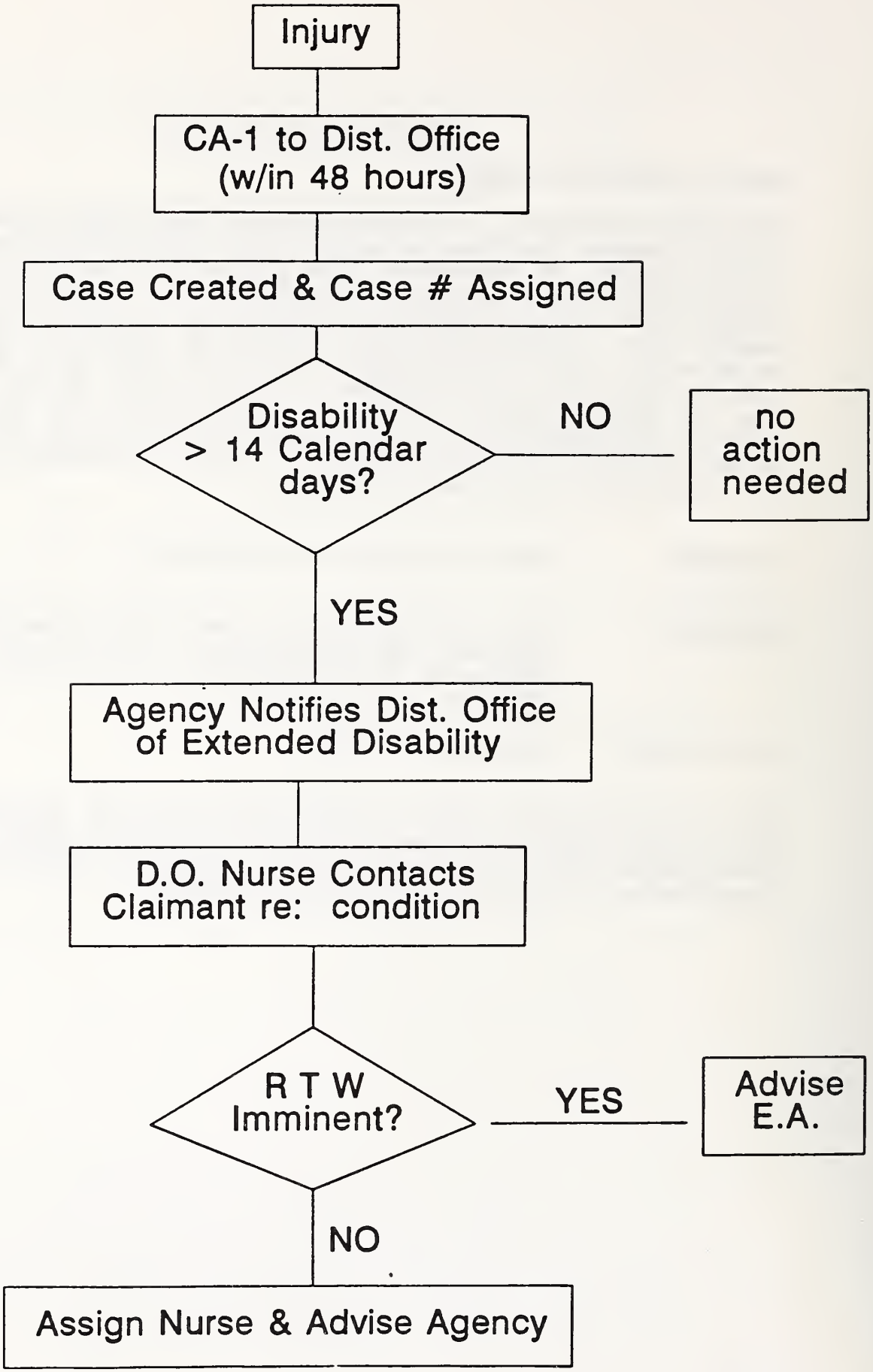
Discussion Group No. 2 defined problems associated with the lag period between the time an injury occurs and OWCP's involvement in the claim. To circumvent this lag, and the consequential inability to begin medical management of a claim soon after the injury, the group developed an outline for a pilot study that would test: (1) the ability of OWCP and an employing agency to resolve the injury notification issue, (2) the value of intervention by a nurse within two weeks of the day of injury, and (3) OWCP's ability to improve their process for gathering medical information on treatment and recovery early on after an injury occurs as a means to enhance timely adjudication of claims and facilitate disability management.

PROBLEM: Early Management of Disability

SOLUTION: Early communication between all of the parties involved, and cooperation on the medical management of the injury

FACILITATOR: Intervention nurse

This group suggested that a pilot study could be implemented in the Boston District Office to test a process for early notification of injuries and early intervention. The following experimental claim flow chart was developed:


Injury
CA-1 to Dist. Office (w/in 48 hours)
Case Created & Case # Assigned
Disability > 14 Calendar days?
NO
no action needed
YES
Agency Notifies Dist. Office of Extended Disability
D.O. Nurse Contacts Claimant re: condition
R T W Imminent?
YES
Advise E.A.
NO
Assign Nurse & Advise Agency

If the claim is assigned to an intervention nurse, then the intervention nurse will:

1. Make an assessment of the injury and the claimant's situation. A set procedure will be followed to:

   - o Document the appropriateness and adequacy of the treatment plan
   - o Coordinate aspects of the treatment plan if needed

2. Familiarize the claimant and treating physician with OWCP claim processing procedures, report requirements, billing methods, etc.

3. Clarify for the claimant the information he/she received from the treating physician and other medical providers, improve the claimant's understanding of the injury, and explain the physician's treatment goals

4. Provide feedback on medical issues, treatment plans, utilization concerns, and expected period of disability to the claims examiner

5. Advise employing agency/supervisor on the injured employee's recovery process, expected availability date for light duty assignment with a discussion of limitations if appropriate, and other return to work issues

6. Make standardized periodic status reports to all parties involved

SUGGESTIONS

Discussion Group No. 2 suggested that the pilot study described in outline be developed and tested in the Boston District Office. A fully developed plan would require a control population and designated objective measures.

DISCUSSION GROUP NO. 3

MEDICAL COST CONTAINMENT INITIATIVES

Discussion Group No. 3 examined cost containment options that might be considered by OWCP:

- HCFA's concept for the reimbursement of inpatient services under Medicare, reimbursement based on Diagnostic Related Groups (DRG's)
- Adoption of the HCFA professional fee schedule in place of OWCP's current schedule with the possible expansion to additional services and durable medical equipment
- Implementation of automated utilization guidelines developed by HCFA and OWCP specific criteria, as well as other options for quality of care review
- Development of outcome measures to improve OWCP's ability to determine the success of cost containment and quality of care review initiatives

Conclusions and Suggestions:

1. The Diagnostic Related Group (DRG) concept could be applied to inpatient bills reimbursed under OWCP. Preliminary analyses by OWCP indicates that use of DRG's for reimbursement of services covered under FECA would reduce costs. Suggest OWCP:

    a. Explore the feasibility of applying the DRG concept to specific programs - FECA, DCMWC and LSHWA

    b. Examine needs for regulatory changes

    c. Determine ADP enhancements necessary to facilitate calculation of the appropriate DRG reimbursable amounts for a specific provider

    d. Consider electronic transmission of bills by hospital providers

    e. Ask HCFA for technical assistance, necessary data support and advice on implementation, including percent add-on for education facilities, capital investments, and other items such as rates for non-acute care facilities (e.g. psychiatric hospitals and rehabilitation centers)

    f. Address the issue of appeals by providers and develop an appeal process

g. Develop a method to monitor application of the DRG system to OWCP programs (sampling methods to determine accurate ICD and primary procedure coding, review of outlier services, etc)

h. Continue the prior authorization of elective surgery and develop a pre-certification process for other elective admissions

2. The HCFA professional fee schedule could be applied to professional service charges under FECA before the HCFA five-year transition period is complete. The schedule may also be applicable to services under the Federal BLBA. It is appropriate for OWCP to use the same value scale (RVS) that HCFA uses for the measurement of the relative "work worth" of medical procedures under Medicare, and that our geographic reimbursement adjustments be based on the same data set that HCFA uses. Suggest OWCP:

a. Explore regulatory change requirements

b. Determine the appropriate reimbursement level for services provided under OWCP programs; e.g. is the appropriate reimbursement level the same for all programs under OWCP; is that different than HCFA's Medicare reimbursement level

c. Examine methods to apply a fee schedule to:

- o Durable medical equipment (HCFA has one established)
- o Pharmaceuticals (e.g. use of prescription mail service)
- o Long-term care facilities (e.g. use of military facilities)
- o Home nursing services (HCFA has established per visit reimbursement limits by geographic area and urban/rural service locations)

d. Ask HCFA for technical assistance, data support, and advice

3. Controls over utilization of medical services under OWCP are necessary for fiscal responsibility and the well-being of injured employees. Suggest OWCP:

   a. Examine implementation of automated utilization guidelines developed by HCFA, and identify others that may be available or developed

   b. Consider the use of utilization review procedures, provider profiling, etc.

4. It is necessary for OWCP to develop procedures to measure the effect of cost containment and quality review efforts. Suggest OWCP determine what objective measures can be applied to their programs (e.g. success need to be measured by a decrease in the common rate of increase).

5. The quality of care under OWCP programs must not be compromised to meet cost containment goals. Suggest that methods for monitoring and measuring quality of care issues be developed and implemented

DISCUSSION GROUP NO. 4

TWENTY-FOUR HOUR COVERAGE OF MEDICAL CARE

Discussion Group No. 4 examined the ramifications of bundling injuries covered under the Federal Employees' Compensation Act (FECA) with a twenty-four hour coverage package of medical care benefits for the Federal workforce, including employees of the U.S. Postal Service. Such a system would, therefore, eliminate the work-relatedness issue of an injury or illness for medical care, and would provide a uniform medical benefits package to all employees, regardless of established causality.

A proposed twenty-four hour benefit package for the Federal workforce was not available. For that reason, this discussion only covered very broad aspects of the issues involved.

Conclusions and Suggestions:

1. Legal Issues

   a. Legislation would be required to change the FECA. It may be difficult to obtain the support necessary for such a major change in the FECA.

   b. Exclusive remedy, the exclusivity of the appeals process, and the employee's exclusion from cost sharing are the traditional foundation of workers' compensation law. If employees are asked to share the cost burden, then incentives to challenge traditional remedies may increase, and breakdown of the system may occur.

      (e.g. It is unlikely that the current medical benefit package for injured employees could be provided to all employees regardless of injury/illness causality, without significant changes in cost burden distribution; the current system requires no contribution by the employee for work-related injuries.)

   c. The "burden of proof" could be shifted: in the case of OWCP it undoubtedly would become more difficult for claims examiners to obtain medical reports on an injured employee's recovery status, current ECAB (Employees' Compensation Appeals Board) interpretations of employee's rights might be revisited, and it could be more difficult for the injured employee to obtain the medical evidence necessary to support a compensation claim.

(e.g. Since the treating physician's fees would be paid under another system, there would be no incentive to provide additional information to either the claimant or the FECA. Additional charges for reporting or examination services not required for treatment, could become a burden for the injured employee, and could create complex reimbursement issues even if the injury is accepted for wage-replacement benefits. In addition, the treating physician could choose not to respond to FECA claims examiners because he/she did not necessarily undertake care with that obligation.)

d. Currently private health insurance plans for Federal employees require co-payments for some or all services; there is no apparent quid pro quo under FECA for introducing copayments by injured employees.

e. The right to choose a physician could be restricted as a means to control costs. Currently this choice is a right for all employees injured on the job and under some private health care plans for Federal employees.

f. The right to pursue third-party payment may be jeopardized.

(e.g. If medical care is reimbursed under another system, those costs would not be under the direct control of FECA; they would have to be pursued by the medical care insurance carrier. If the insurance carrier does not pursue third-party payment, the premiums for all Federal workers and agencies could increase. FECA could pursue reimbursement for wage replacement benefits.)

g. The feasibility of designing a 24-hour benefit package that would meet current medical care requirements under FECA is questionable: FECA medical benefits are very comprehensive and it is unlikely that such a package could be affordable for all injuries and illnesses under a twenty-four hour coverage plan in the nation's current health care environment, especially one that would eliminate co-payments by users of the system.

2. OWCP Administrative Considerations

a. It would be more difficult to obtain information necessary to process a claim from the treating physician since payment for services would no longer be an issue.

b. The necessity for independent medical examinations might increase if the treating physician chooses not to become involved in the legal issues relating to the injury/illness.

c. The question of causality still exists under twenty-four hour coverage for the payment of wage replacement and other associated benefits (e.g. scheduled awards); a mechanism would have to be developed to obtain medical evidence, answer possible causality issues, determine extent of recovery, release for work, etc.

d. If a system with co-payments were implemented, medical service utilization might be reduced, but it could also lead to inadequate care, possibly resulting in long-term disability benefits for industrial injuries.

e. There would be a considerable reduction in OWCP administrative costs if the need to process medical bills was eliminated. Also, it might eliminate or postpone the necessity to pursue claim adjudication in all those instances where no lost time occurred. This could create problems later, however, should lost time occur.

3. General Considerations

a. The direct incentive for work place safety may be considerably softened since the impact of medical care costs on the employing agency's budget is eliminated. Currently there are no penalties for injury rates other than the cost burden. Assessing additional burdens because of injury rates could be difficult; federal agencies do not have uniform distribution of occupations (e.g. air traffic controllers, U.S.Postal Service) and do not, therefore, provide a broad base for rate setting as is found in the private sector where similar, but independent, industries are rated.

b. Portability of health care benefits would improve if all employers subject to workers' compensation laws were required to provide a twenty-four hour package for medical care; a universal health care system would eliminate the portability issue.

c. Under twenty-four hour coverage, universal coverage for all Federal workers would be required because all are at risk for a work-related injury. Currently about 16% of employees are not covered under a government-sponsored health care plan. If the current funding mechanism requiring employee contributions to general health care plans is maintained, then equal contributions by employees not now covered would be necessary. The insurance carrier would not identify industrial injuries/illnesses and all employees would become contributors to the cost of care for all services, contrary to the current system where the employer and/or responsible third parties are the sole source for funds in the instance of work-related injuries.

SUGGESTIONS:

1. Discussion Group No. 4 believes more study of the twenty-four hour coverage concept for Federal employees is required.

2. A specific plan for twenty-four hour coverage would have to be developed if an in depth discussion is to occur and informed suggestions made.

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U. S. Department of Labor
Office of Workers' Compensation Programs

The Office of Workers' Compensation Programs (OWCP) in the United States Department of Labor administers workers' compensation programs for federal employees and certain private employees, which provide benefits for on-the-job injury to covered workers, and compensation and medical care to their survivors in case of work-related death.

The Federal Employees' Compensation Act

Coverage & Benefits: The Federal Employees' Compensation Act (FECA) covers more than three million civilian employees in seventy-seven agencies of the United States government (and certain other employees). It provides for benefits for disability due to work injury or illness, including: compensation for lost wages due to disability for work; payments for loss or loss of use of members and organs of the body; medical treatment; vocational rehabilitation; and payments to survivors.

Over 170,000 injury and illness reports are filed each year, of which ten percent are claims of work-related disease and the remainder are traumatic injury (accident) reports. At any given time, about 20,000 claimants are judged to have longer-term disability for work and are potentially eligible for vocational rehabilitation services. Orthopaedic injuries, particularly injuries to the low back, knee, wrist, and so on, are the most common conditions for which benefits are awarded.

In the case of a traumatic injury (accident) the employer continues the employee's regular pay for up to 45 days of disability (called continuation of pay or COP). After that period, if total disability continues, compensation for the wage loss is paid at two-thirds of the worker's salary if there are no dependents, or three fourths if there is one or more dependents. Compensation for disability due to occupational illness (such as occupational asbestosis) is made at the same rate, but COP is not available. If the disability is partial, that is an individual is unable to earn as much following the injury, then reduced benefits may be paid taking into account the amount of wages which can be earned.

The FECA also provides a schedule of members or organs, such as a leg or eye, for which a specified amount may be paid for their loss or loss of use. OWCP also provides for all physician services, medicines, supplies, and hospital care prescribed or recommended by qualified physicians for treatment of an injury. The employee may initially choose his or her physician.

Adjudication & Administration: FECA claims are adjudicated and managed in twelve district offices around the United States. Field staff numbers about 800. Claims examiners in each district office review reports of injury, request factual and medical evidence as needed, and make a determination to accept or deny the claim. They are also responsible for managing the medical progress of the case and for approving compensation payments until the claimant can return to work. When a claimant is judged to be unable to return to his or her old job, the claims examiner refers the claimant for an evaluation for vocational rehabilitation services. The claimant or the employing Federal agency may also request services. If it is determined the claimant is a viable candidate, appropriate efforts at placement and training may be undertaken.

OWCP is a neutral adjudicator of claims and the adjudication of claims is nonadversarial. The employees' union may represent claimant, comment on policy or support legislative change. Employing agencies may provide information or request justification for a decision, but have no appeal from any decision. Claimants have different appeal and review options they may follow if they disagree with a decision. They may request reconsideration from the district office at any time, request a hearing from an OWCP hearing representative, and they may appeal any of these decisions to the Employees' Compensation Appeals Board, an independant body within the Labor Department. The courts have no jurisdiction over entitlement issues.

Funding: Benefits are paid from the Employees Compensation Fund, and charged back to the agencies. Appropriated fund agencies include their workers' compensation costs in the annual budget request to Congress; the Postal Service, TVA and some other agencies pay these costs out of operating revenues. Non-appropriated fund agencies like the Postal Service and TVA also contribute to the administrative cost of the program on a pro rata basis.

The program paid out over 1.7 billion dollars in benefits in 1992: $1.3 billion in disability compensation and survivor benefits and $419 million in medical benefits. Its administrative budget is about $60 million.